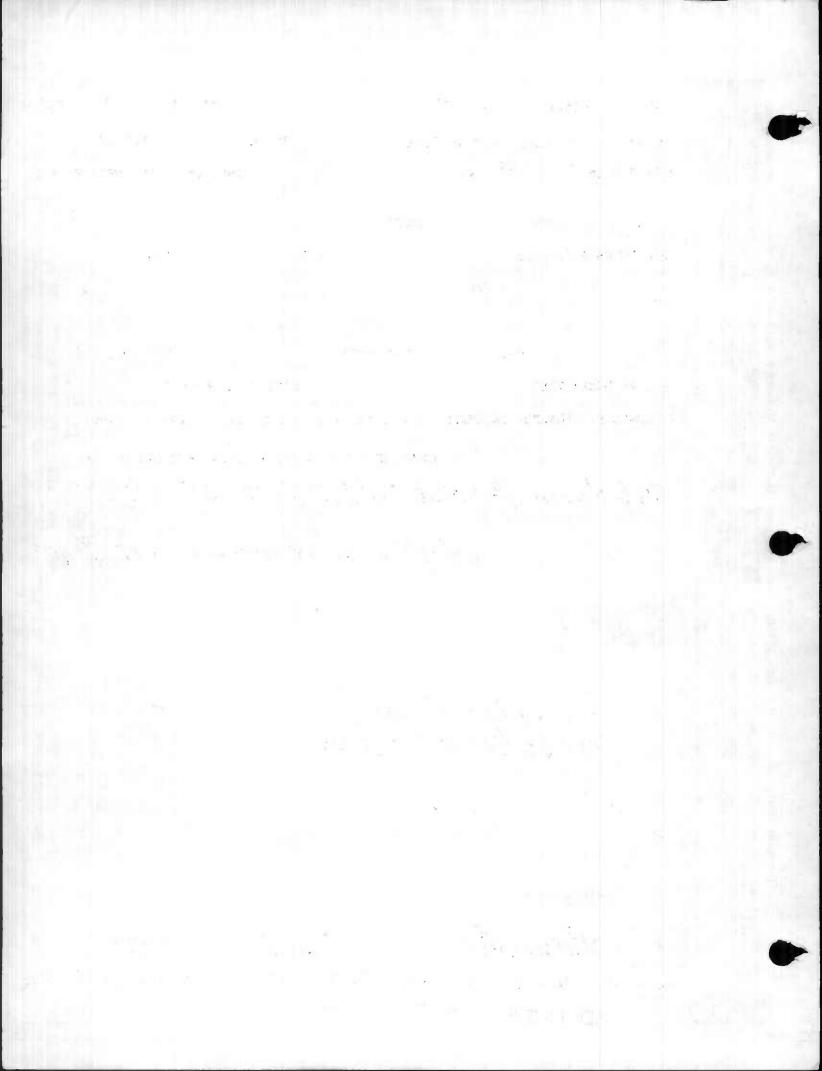
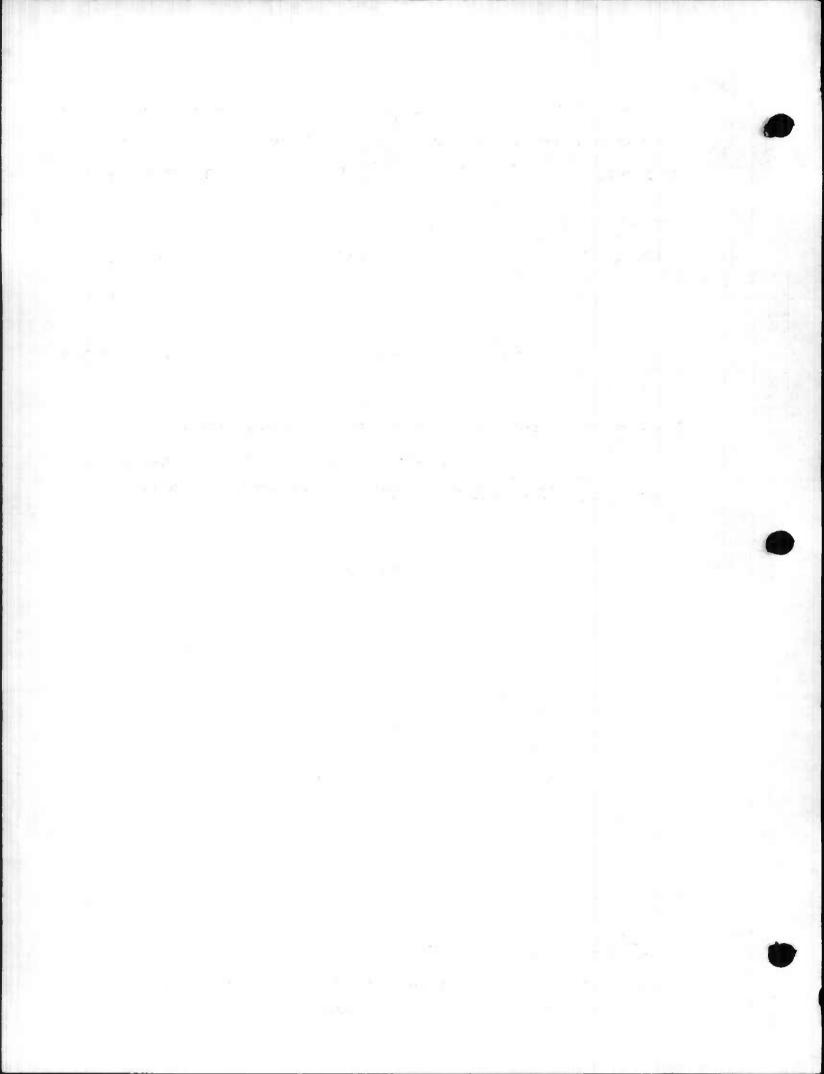
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1998 Nora Fluharty 9 12:05AM Sept Olive /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Genesis ElderCare -The Pines Easton If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (Stata or Foreign Country) **Funeral** 1□M 2XX Months Days Yrs. Director 220-32-0826 98 JUNE 25, 1900 PENNSYLVANIA Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov other treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with ò 234 610 DUTCHMAN'S LANE 21601 USA Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mantal Hygiene. Important: if tiem 27 is marked other there any injury or other treasment. Herna 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes XZXNo It Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Business/Industry (Spacify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Malden Surname) SAMUEL HENRY WISE PHOEBE MAE MORRIS 10 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Coda) FLORENCE H. LEONARD/ DAUGHTER 201 FEDERAL ST., APT. 14, EASTON, MD 21601 20b. Place of Disposition (Nama of camatery, cramatory or othar place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal trom State TILGHMAN MEMORIAL CEMETERY 9-13-98 TILGHMAN, MD 4 ☐ Donation 5 ☐ Other (Spacify) 22. Name and Address of Fecilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ALDIOVASCULAR. Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequenca ot) Examiner attending physician end for use es the bunal-transit requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence ot) 80 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 8 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA After this uneral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? after death.

I Director: After to in by the funers 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide To the Hospital o within 24 hours aft To the Funeral Di completaly filled in 29a. Certifier 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the tima, dete end plece, end due to the ceuse(s) and manner as steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartil 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) STRUCT ST MD 800 1AU30T 21663 NIMAM 31. Date filed (Month, Day, Yaar) 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

					Cer	lincale	of Death		Reg	. No.		
Dhualai		1. Decedent's Neme (First, Middle,	Last)					2	. Dete of Deeth Month	Dey	Year	3. Time of Dee
Physicia /Medic	_	Deborah C. Frye						Se	ptember	6, 19	98	13:00
Examin		4a. Facility Neme (If not institution,	give street end number)				4b. City, Tov	vn, or Loca	tion of Deeth	4c. County	of Deeth	
	-	Greater Baltime	ore Medical	Cent	er		Tows	on		Balti	more	
Funeral Director		5. Social Security Number 217-96-9808 Usual Residence of Decedent	5. Sex 7. Ag	e (In yrs. le 33	st birthday) Yrs.	If Under 1 Months	Year If Under 2 Deys Hours	Min.	Dete of Birth (Month, Dey, Y	ear)	9. Birthpled	ce (Stete or For i)
M		10e. Stete 10b. County		10c. City,	Town or Lo	cation		-			100	. Inside City Lir
Page 1	tor	Maryland Howard		High	land							1 ☐ Yes 2 🕱
or 28	ire	10e. Street end Number				10f. Zip C	ode		100	. Citizen of V	Whet Country	n
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- 1	by Funeral Director	11. Maritel Stetus 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 It Yes, Give Yeer or Detes;		1	Vas Decede Yes, specif	nt of Hispenic Orig Cuben, Mexican No Specify:	ln? (Speci Puerto Ri				
natu fical	ted	15. Decedent's (Specify only highest	Education		16e. Deced	ent's Usuel	Occupetion	of working	16	b. Kind of Bu	ısiness/Indu	stry
than "	Be Completed	Elementery/Secondery (0-12)	Coilege (1-4or !					during most of working d)				
Hygie If, III	ပိ	17. Father's Neme (First, Middle, La	l year	Office Manager 18. Mother's Na					Training Busines Name (First, Middle, Meiden Surneme)			
ed o		John W. Chesson	,				_			odii Sometii	10)	
d Me mark matic	2	19e. Informent's Name/Relationship	D. (Time Print)		Donna J. Jones 19b. Melling Address (Street end Number or Rural Route Number, City				Situas Tours	Ctata Zia C	o dal	
trau											Stete, Zip U	000)
Heat m 2 ther		Tony Scott Frye 20e. Method of Disposition	(Husband)	20b. Ple	13886 ica of Dispos	o Rt 1	08 Highl			c. Location -	City or Town	State
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hysician /Medical xaminer		1 111		_			Old Lib					1784
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D ed									1 □ Yes 2⊠ No 3 □ P			bly 4□Unki
should be d	Completed by							24e. Wes an a performe		eveil	autopsy tindin able prior to pletion of cause ath?	
has been e 2 shoul	Idm						6.5		1 🖾 Yes	2 No	1020	res 2□ No
ate has page 2												
ate has page 2	Be	25. Was case reterred to medical examiner?						of Deeth (Check only one)			
his certificate has al director, page 2	To Be	examiner? 1 Yes 2 No			R/Outpatien		Other: 4 Nu	sing Home	5 Resident	ce 6 □Oth		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Mary Elizabeth Gilmore **Physician** 7:15 p.m. SEPTEMBER 8, 1998 /Medical 4e Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL & MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) West Virginia 5. Social Security Number 8. Dete of Birth (Month, Dey, Yeer) Deys Hours 1 M 2 KF 81 234-46-6798 Aug. 8, 1917 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits WV Mineral Piedmont 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 14 West Harrison Street 26750 United States Funeral Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black þ 3 X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Unknown Homemaker Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Dave Green Ethel Price 19a, Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 107 E. Hampshire St. Piedmont, WV Rita Wheeler 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Thorn Rose Cemetery 9/12/98 Keyser, WV 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility 111 Church Street a Boal Funeral Home Westernport, MD 21562 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel 2-3 Years Myelodysplasia Transforming into Acute Leukemia disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to Immediete ceuse. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of):

Physician /Medical

permit. Pages 1 and 2 should be filed w Department of Health end Mental Hygien important: If Item 27 Is marked other th party injury or other traumatic event, tra page.

Funeral

Director

ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

with the Maryland

death v

filed within 72 hours efter

altimore, Maryland 21215-0020

Examiner physician end the buriel-transit d for use es t

The law requires that the death certificate be executed P.O. Box 68760 signed by the et d be detached for page 2 certificate director, this funerai

Records, Division of Vital Hospital or Attanding Physician: After deeth. ofter deet Director: filled in by A 24 hou. The Funeral P completely To the within 2

GILMORE

Examiner Physician/Medical 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy Completed 1 ☐ Yes 2 No 1 □ Yes 2 □ No 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1☑Inpatient 2☐ER/Outpetient 3☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical 29e, Certifier (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner stelled.

29b. Signeture and tille of certifier

MD

29c. License number D 23371

SEPTEMBER

29d. Date signed (Month, Dey, Year)

1998

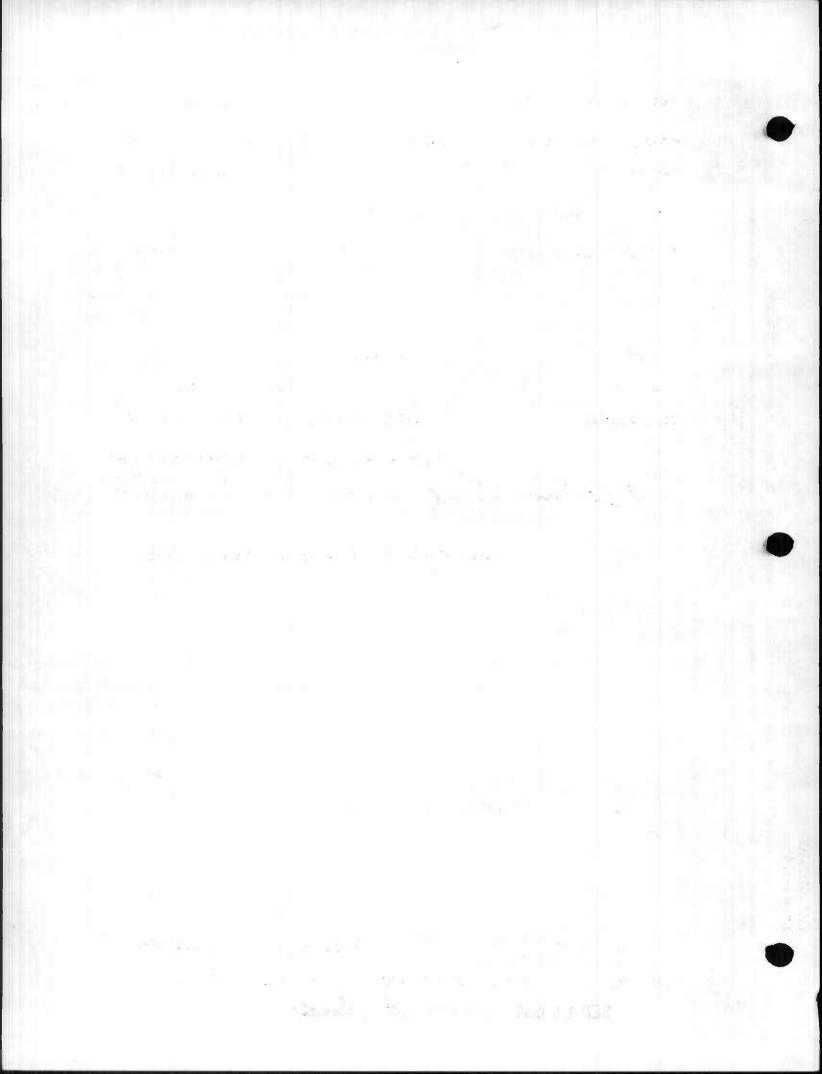
30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

QAMAR ZAMAN, M.D. 625 KENT AVENUE, SUITE 102 CUMBERLAND, M.D. 21502

State Registrar 31. Date filed (Month, Dey, Year) SEP 1 0 1998







Baltimore, Maryland 21215-0020 FERMAN,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

1. Decedent's Neme (First, Middle, Last)

5. Social Security Number

10e. Street end Number

10e. State

MD.

11. Maritei Status

530-64-2713

Usuel Residence of Decedent

7510

1 Never Married 2 Married

3 MWidowed 4 Divorced

Elementery/Secondary (0-12)

KAROLINE

DOCTORS COMMUNITY HOSPITAL

PRINCE GEORGES

WILHELM DR.

15. Decedent's Education (Specify only highest grade completed)

1 M 2 F

4e. Facility Neme (If not institution, give street end number)

10b. County

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryle Department of Health end Mental Hygiene. important: If them 27 is marked other than "naturel", or thems 23e or 28s-4 shown hy Injury or other treumatic event, the Medical Examiner must be notified at once. Completed by College (1-4or 5+) HOUSEWIFE 17. Fether's Name (First, Middle, Last) Be P JOSEF 19a. Informent's Neme/Relationship (Type, Prin ROBERT J. GERMAN/SON 20e. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 ☐ Removel 4 Donetion 5 Other (Specify) 21. Signeture of Funerel Servica Licente 23e. Pert1. Enter the disease, or complicatione shock, or heert failure. List only one cause **Physician** /Medical tmmediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner Attending Physician: The law requires that the death certificate be executed **buriel-trensit** Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last end Division of Vital Records, P.O. Box 68760, ettending physician for use es the burie Completed by Physician/Medical the been signed by the e should be deteched f Pert II. Other significant conditions contributing 1)1719 hes After this certificate director Be 25. Wes case referred to medical exeminer? Hospital: Medical Certification: To 1 ☐ Yes 2 ☐ No To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Menner of Deeth 28e. [5 Pending investigation Naturel 2 Accident 3 Suicide 6 Could not be determined 28e. F 4 Homicide

Birthpleca (State or Foreign Country)

VIENNA AUSTRIA

10d. inside City Limits

1 X Yes 2 No

3. Time of Death

1:56 Pm

2. Dete of Deeth

8. Dete of Birth (Month, Dey, Year) OCT. 15,1919

4b. City, Town, or Location of Deeth

LANHAM

If Under 24 Hrs. Hours Min.

eptember 3, 1998

4c. County of Deeth

10g. Citizen of Whet Country?

Specify

16b. Kind of Business/Industry

U.S.A.

Race - American Indien, Bleck, White, etc.

AT HOME

WHITE

PRINCE GEORGES

(First, Middle, Last)			18. Mother's Ne	me (First, Middle	, Melden Sumen	ne)
OSEF T.	EGGENFE	LLNER		KAROLI	NE I	ŒRNER
eme/Relationship (Ty	pe, Print)	19b. Mailing Address (S	treet end Number or F	Rural Route Numb	er, City or Town,	Stete, Zip Code)
J. GERMAN	/son	SAME AS	ITEM #10			
position		Ob. Pleca of Disposition (Neme	of	Dete	20c. Location -	City or Town, Stete
Cremetion 3 🗆 R	emovel from State	cemetery, cremetory or othe		- 1- 1-0		
5 Other (Specify)		CHAMBERS CREM	ATORY	9/5/98	RIVE	RDALE, MD.
nerel Servica Licorm	0 0	22. Name end A	ddress of Fecility			
W/16/11.	en housell_m	00091 CHAMBERS	S FINERAL	HOMES P	A RTVE	ERDALE, MD.20737
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rt failure. List only or	ne cause on each line.					Intervel Between Onset end Deeth
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icant conditions con	tributing to death but no	ot resulting in the underlying ceus	se given in Pert I.	23b. Dld	TODACCO USe CO	ntribute to the cause of death?
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12.1				-		
				24e. Wes	en eutopsy ormed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
				10	Yes 2 No	1 ☐ Yes 2 ☐ No
red to medical			26. Plece of De	eth (Check only	one)	
No H	ospital:	2 ER/Outpatient 3 DOA	Othor	Home 5□ Resi		er (Snecity)
h	28e. Dete of Injury				how injury occur	
5 Pending investigation	(Month, Day Yea	ar) Injury M	Injury et Work? 1 ☐ Yes 2 ☐ No		,,	
6 Could not be determined	28e. Pleca of Injury -	At home, farm, street, fectory, of	ffice	28f. Location (Street end Numb	per or Rural Route Number,
	building, etc. (S	peony)		City or To	wii, Stete)	
Certifylna Phys	Iclan: To the hest of mu	knowledge, deeth occurred et ti	he time dete end clas	a and due to the	cause/s) and me	anner as stated
2 Medical Examir	er: On the besis of exer end menner stated.	minetion end/or Investigation, in	my opinion, deeth occ	urred et the time,	dete end pieca,	and due to the ceuse(s)
title of partifica	A A	00.11			004 Data	d (March Brus March
title of certifier	h /		cense number			d (Month, Dey, Year)
Konn	B Nura	lean lot	D0589	7/	9-4-	98
ess of person who co	mpleted cause of death	(Item 23e) (Type, Print)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
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CHAM,		IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	UILL, #	LITURY!	DIVEKL	1-100 1110 W13/
TO 0 100	32. Registrer's S					
EP 0 8 199	8 June	p. pps	res			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Year Months Deys

LANHAM

10f. Zip Code

1 ☐ Yes 2 ☐ No

20706

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

GERMAN

Yrs

10c. City, Town or Location

7. Age (In yrs. last birthday)

78

Μ.

12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:

State

Registrar

8

29a. Certifier

29b. Signeture end title of certifie

31. Dete filed (Month, Dey, Year)

30. Name end eddress of person who completed MOHOM

SEP 0 8 1998

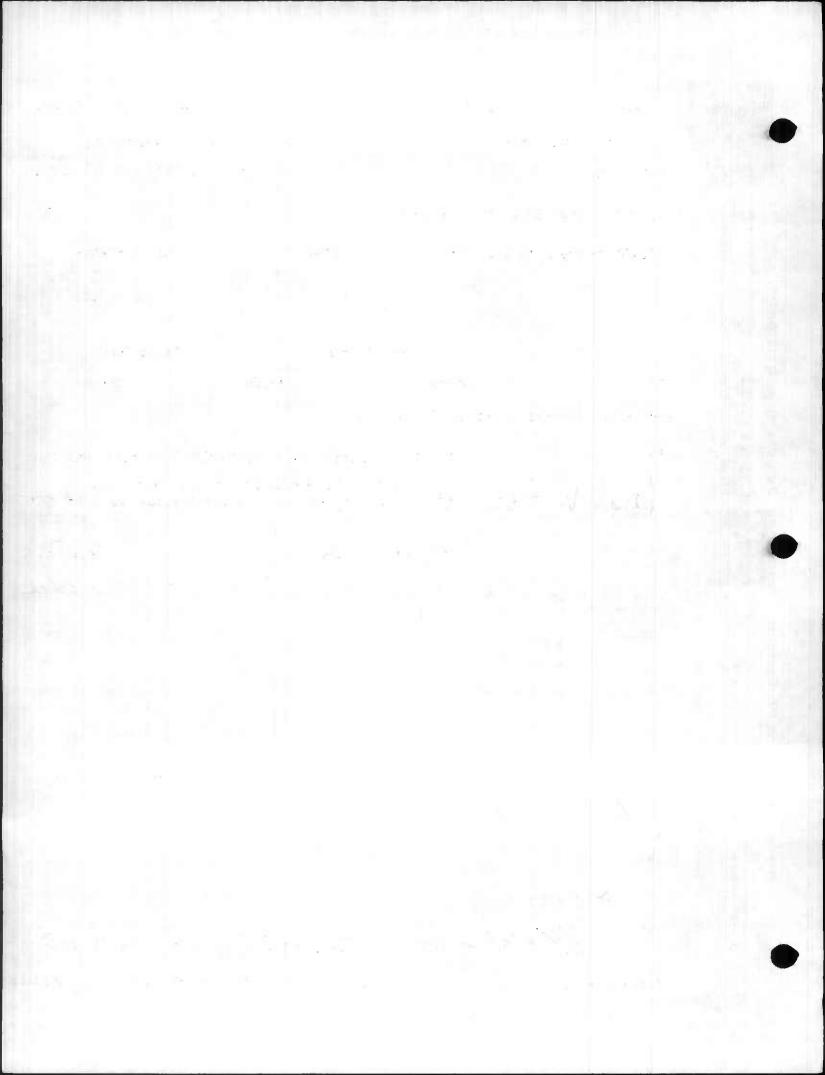
dis di min STATE OF THE STATE to water the to TE MINERAL V N The state of the s But have been been been and and

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 1998^{Year} **Physician** Sept. 6, 8:00P. Viola Goodrich May /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Holy Cross Hospital Silver Spring Montgomery Hours Min. 8. Dete of Birth May 1920 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1 M XXF Months Deys South Carolina 78 249-26-2090 Director Usuel Residence of Deceden the Maryland 10c City Town or Location 10d Inside City Limits 10a State 10b Count "natural", or items 23a or 28a-f show 1 Yes XX No Prince George's Beltsville Maryland Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 20705 United States 11378 Cherry Hill Rd., #104 Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or Itema 23 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes XXNo
If Yes, Give
Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11 Marital Stetus Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: Specify: White à 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Meat Wrapper Giant Food 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Clarence Coates Melinda. Turner 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) same as #10 Richard Dee Goodrich (Husband) or other 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1X Burial 2 Cremetion 3 Removal from State 9/12/1998 Rockville, Maryland Parklawn Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Donald V. Borgwardt Funeral Home, P.A. 21. Signa THE OF FUNERAL Service License 4400 Powder Mill Rd. Beltsville, Maryland 20705 Approximete Interval Between Onset and Death Pe 11. Enter the disease, or comp shock, or heart feilure. List only Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** neumonia /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Heart Failure Examiner physician and s tha burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of) attending pl signed by the al Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yae 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an eutopsy Completed certificata has lirector, page 2 : 1 ☐ Yes Hospital or Attending Physician: 124 hours after death. Funeral Director: After this certifical director. 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Yes Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Deetl 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Naturel 5 Pending investigation rector: Af by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier edical 29d. Dete signed (Month, Day, Year) 29b. Signature end title of cartiful 29c. License number September 7, 1998 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia AJE #340 S. IVER Spairs MD 20902 M1). Jeffner P. INDRISA NO 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture Registrar SEP 0 8 1998

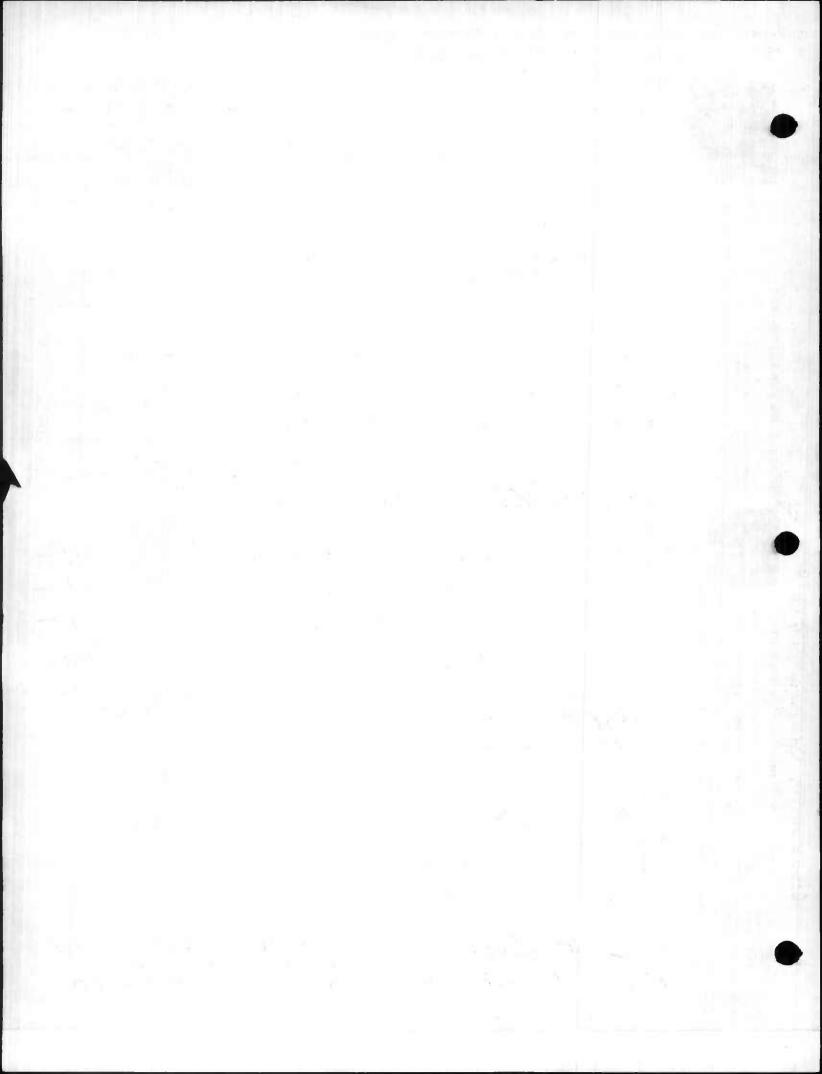
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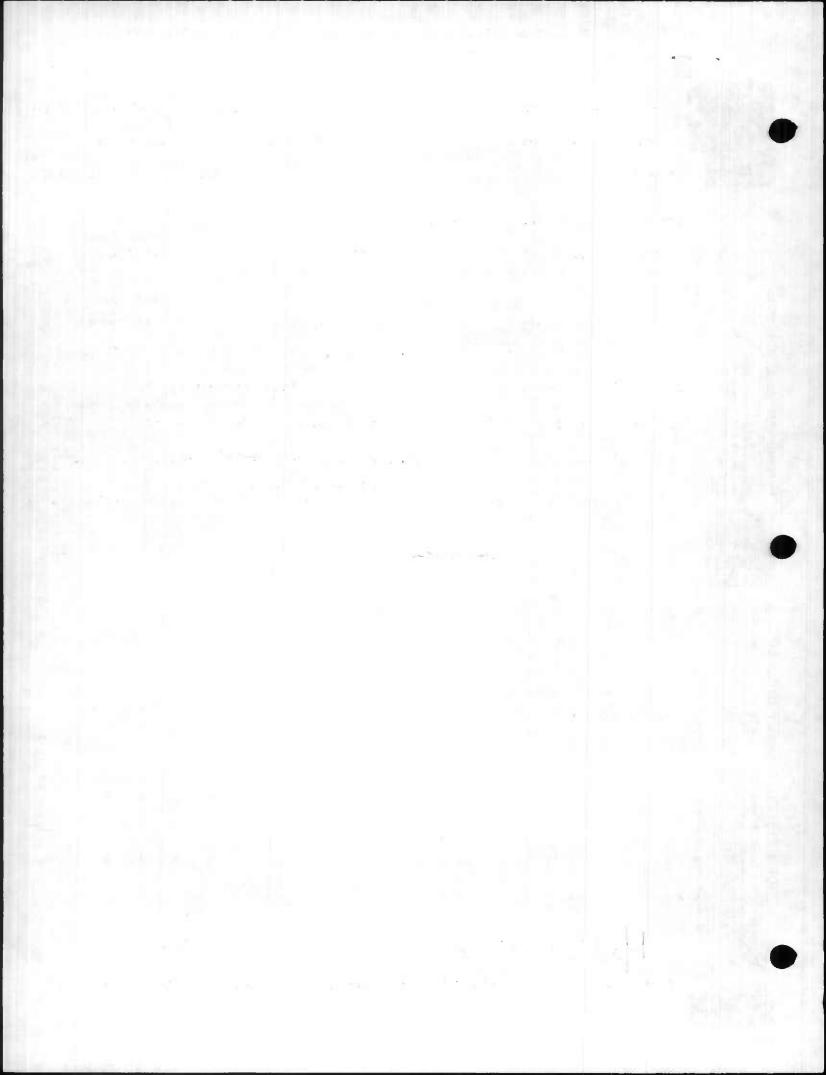
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Exami		4a. Facility Nama (If not institution, gi	va street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Deeth	
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Funeral			Sax 7. Ag 1 ☐ M 2 ☑ F	ga (In yrs. last bir	Months Day	er If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day)	Year)	9. Birthpian	ca (Stata or Foreign
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158 the	Director	10e. Street and Number	mery	De	10f. Zip Code	V	1	0g. Citizan of	What Country	v2
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Jaseth Tre 23	Funeral	11. Marital Status	12. Was Dacadanf	Evar In U.S.			pacify Yas or No-			n Indian
faryland 21215-0020 2 should be filed within 72 hours after death with the Manfand and Mental Hygiene. Is marked other than "natural", or fisms 23a or 28a4 show surmatic event, the Medical Examiner must be notified at	Fur	1 ☐ Navar Married 2 ☐ Marriad	Armed Forcas?	-1111		f Hispanic Origin? (Spuban, Maxican, Puarto	o Rican, atc.)	atc.) 14. Race - American Indian Black, Whita, atc.		
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yla Nen Men Men arke	2	Gerald A. Cheese	man			Marie B	rodbeck			
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and Ftran	Examiner	Sequentially list conditions, if any, laading to immadiata		Dua to (or as a d					.11	
6876U, ificate be ax g physician as the burial	E III	causa. Entar Undarlying Causa (Disaasa or Injury	RU	PTUNEO	ANEU	RYSM				41
rificate be axecuted ng physician and as the burial-transit	Medical	Causa. Entar Undarrying Causa (Disaasa or Injury that Initiated avants rasulting In death). Last Dua to (or as a consequence of):								10
OX O					10 yns					
ath ce attendii for use	lan		dI	7 7	TENSIEN					
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or Atter efter des Director	Ē	4 Homicida datamined	28a. Placa of Inj	ury - At home, fa c. <i>(Specify)</i>	rm, streat, factory, offic	0	28f. Location (St City or Town	reat end Numl n, Steta)	er or Rural F	routa Number,
To the Hospital or At within 24 hours efter or To the Funeral Direct completely filled in by		One Continue								
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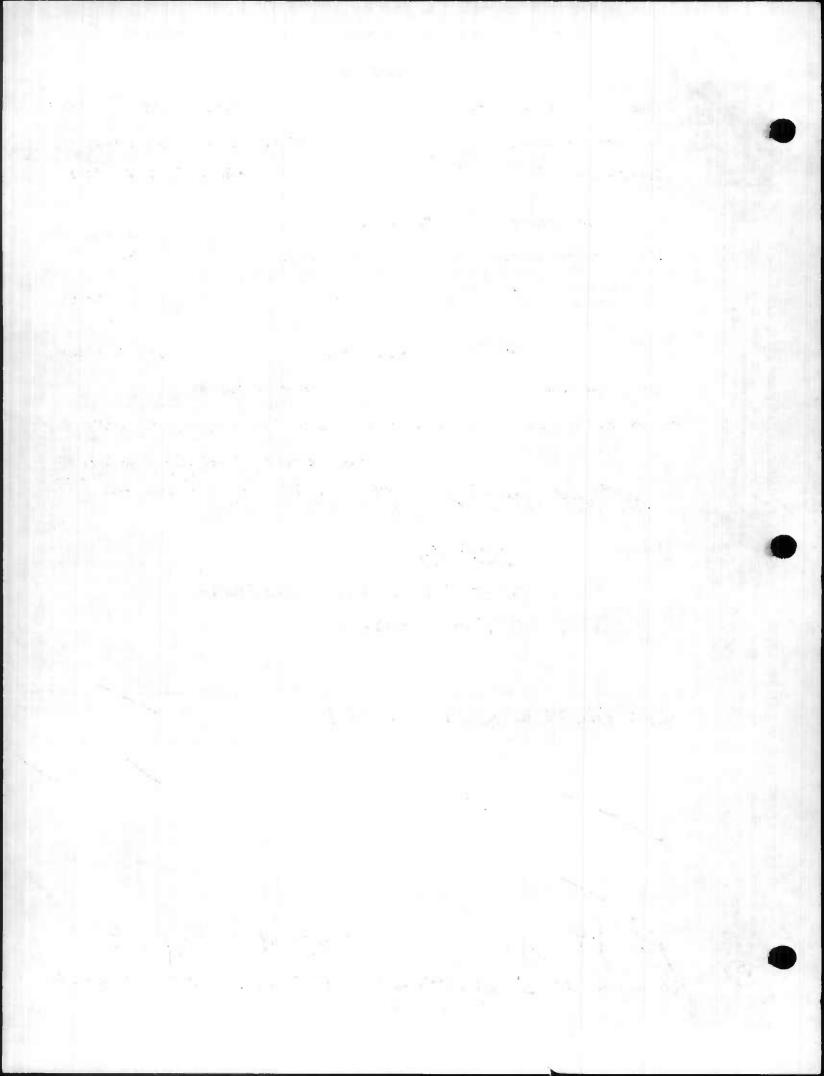
Au III	Item: 23 part I, per Ph)/6/98 G	rtificate of	Death	2. Date of D	Reg. No.	3. Time of	
Physician	Phil George	Goulding				Septem	ber 8. 1	998 7:55	AM
/Medical Examiner	4a Facility Nema (If not institution, g				4b. City, Town	n, or Location of Dea			
Camine	13205 Carriage			M Hadar 4 Van	Rockvi		Montg		
Funeral Director	5. Social Security Number 6. 294-09-7110 Usual Residence of Decedent	4 C 14 0 C C	yrs. lest birthday, 77 Yrs.	If Under 1 Yea Months Days		Min (Month, I	28, 192	9. Birthplace (State of Country) 1 Californ	or Foreign nia
ehow dat	10e. Stete 10b. County	10	c. City, Town or L	ocation				10d. Inside Ci	
the Maryla 28a-f ehor notified	Maryland Montgo	mery I	Rockville	е				1 □ Yes	2€ No
offer death with the Maryland w items 23s or 28s-f show in the must be notified. Funeral Director	10e. Street and Number 13205 Carriage C	ourt		10f. Zip Code 20850			10g. Citizen of V		
or he	11. Marital Status 1 □ Nøver Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	100	1943- 1946	Was Decedent of If Yes, specify Cu 1☐ Yes 2☐ No	ban, Maxican, I	n? (Specify Yas or N Puerto Rican, etc.)		ca - American Indian, ck, White, etc. White	
n 72 hours natural', natural',	15. Decedent's I (Specify only highest g	Education	16a. Dece	edent's Usuel Occi	upation	of working	16b. Kind of B	usiness/industry	
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shou nd M mer	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stree	et end Number	or Rural Route Num	nber, City or Town,	Stete, Zip Code)	
nd 2 alth e	Miriam B. Gouldi	ng (wife)	1320	5 Carria	ge Cour	t, Rockvi	lle, Mar	yland 2085	50
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that the ed by th detache	colon cancer					10	23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4		
or attending Physician: The law requires that the death cefter death. Director: After this certificate has been signed by the attend if in by the funeral director, page 2 should be detached for us ertification: To Be Completed by Physician/						24a. We	as an autopsy rformed?	24b. Were autopsy available prior completion of of death?	to
The land						10	Yes 2 No	1 ☐ Yes 2] No
sician: The law s certificate has t firector, page 2 s	25. Was case referred to medical				26. Plece o	of Death (Chack only	y one)		
Physician: this certific ral director. To Be	examiner? Y	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA	ther: 4 Nurs	sing Home 5 Re	sidenca 8 🗆 Oth	er (Specify)	
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al or Ath I Direct od in by 1	3 ☐ Suicida 6 ☐ Could not 4 ☐ Homicide determine		At home, ferm, si pecify)	treet, factory, office	3	28f. Location City or 7	(Street end Numi Town, Stete)	ber or Rurel Route Nun	nber,
To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affar completely filled in by the fune Medical Certification		hysician: To the best of mainer: On the basis of exa and manner stated.							s)
Toth comp	29b. Signature and title of confirer	nurel w	D	D29	nsa number 9229			er 8, 1998	
	30. Name and address of person who Martin Kanovsky				, Suite	730, Che	vy Chase	, MD 20815	5
State Registrar	31. Dete filed (Month, Day, Year) SEP 1 0 19	32. Registrar's	- /.	Spar	6				

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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician 1998 Vincent A. Goudreau, Sr. Sept. 6, 1:27PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Feb. 2, 19 5. Social Security Number If Under 1 Year 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1 X M 2 F Months Days 88 Yrs. 569-36-3204 1910 Michigan Director Usual Residence of Deceden the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at 1KI Yes 2 □ No Director MD Montgomery Takoma Park 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? with 7427 Baltimore Avenue 20912 USA Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yas, Give Year or Dates: WWII Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Menial Hygiene. nt: if Nem 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by White 3 Nidowed 4 Divorced WWII Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Accountant Federal Government 17 Fathar's Nama (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred Goudreau Rose Charboneau 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Vivan Place, Silver Spring, MD Vincent A. Goudreau, Jr. (son) 20902 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 9/11/98 Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral 21. Signature of Funeral Service Licansee 500 University Blvd. West Home, Inc. Silver Spring, MD 20901 Silver Spring, MD 20901

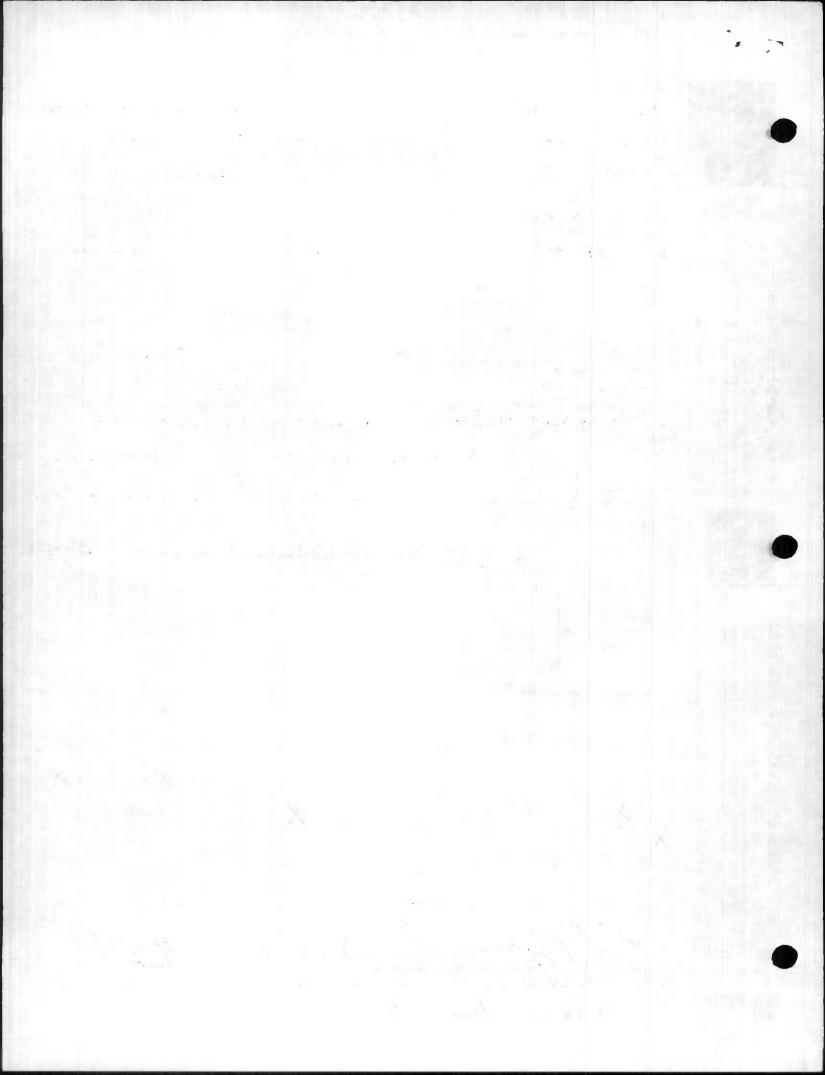
23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner BOWER CTED INFARCTION physician and the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last Due to (or as a consequence of): ATHEROSCLE ROSIS P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 88 attending esn 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy peen performed? page 2 2100 1 Yes 2000 1 Tyes certificata Division of Vital I or Attending Physician: after death. Director: Aftar this certifica director. 25. Was case referred to medical Be 28. Place of Death (Check only one) Hospitai: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 NA funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarminad 3 Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifier Medical To the To the To the 29b, Signature and title 29d. Date signed (Month, Day, Year) 29c. License number deple 25 10 30 Name and address of person w no complated causa of daath (Itam 23a) (Type, Print) SILVER SPRING, MD MUSGRUE RD #209 KODENJ. GINSDEM 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State Registrar SEP 08 1998



State of Maryland / Department of Health and Mental Hygiene

		4 December 10 Name (First Middle Le	n d l	06	rtificate of	Death	2. Dete of Deet	eg. No.		3. Time of Death	
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	/Medical		Grabis				Septemb			4:20pm	
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	Funeral Director	340-22-0109	X M 2 □ F	96 Yrs.	Months Deys		8. Date of Birth (Month, Dey, Nov. 12	Year) 2,1901	9. Birthple Country Kans	ce (Stete or Foreign y) 3 AS	
	pue *	Usuel Rasidenca of Decedent 10a. Stete 10b. County		10c. City, Town or L	ocation				100	d. Inside City Limits	
	vith the Maryle or 28a-1 sho be not the Director	Md. Freder	ick	Frederi						1 ☐ Yes 2Ñ No	
	th with the 23a or 24 and be no	10e. Street and Number 920 McLendon Dr	ive		10f. Zip Coda 21	702	10	Og. Citizen of V	Whet Country d Stat	*	
020	72 hours after death with the Maryland natural; or items 23a or 28a-f show area Examinar must be notified at seed by Funeral Director	11. Maritel Stetus 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Wes Decedent B Armed Forces? 1 Yes 2 N N If Yes, Give Yeer or Detes:	Ever in U,S. 13.	Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		pecify Yes or No- o Rican, etc.)	Bled	14. Rece - American Indien, Bleck, White, etc. Specify: White		
21215-0020	within sne.	15. Dacedent's El (Specify only highest green Elementary/Secondery (0-12)	ducation ode completed) College (1-4or 5	+) (Giv		one during most of working etired)			stry		
		12		Me	chanic	10 Mathada Nas	ne (First, Middle, A	Trucki	9		
⊆ .	permit. Peges 1 and 2 should be fill Department of Health and Mental H Important: if Item 27 is marked oth any Injury or other traumatic sven pncs.	17. Fether's Name (First, Middle, Last) John A. Grabi					Weikert	naiden Sumen	16)		
2		19e. Informant's Name/Ralationship ((ep) 19b. Mei	ling Address (Street			City or Town.	Stata. Zip C	Code)	
Z S		Mrs. Dorothy Din	(00	CP)	0 McLendo						
0		20e. Method of Disposition	- (0	20b. Place of Disc	osition (Neme of	Ţ		20c. Location -		n, Stete	
OL OL		1 Buriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specif			Heaven		Sept 8, 1998	Silver	Sprin	g,Md.	
=		21. Signeture of Funeral Service Licer			22. Neme end Addre	ess of Fecility D	eVol Fun			(3 20077	
		23a. Part1. Enter the disease, or com	dely			Deer Parl				Approximete	
	ificate be executed as the burial-transit as the burial-transit edical Examiner	Immediate Causa (Final disease or condition rasulting in death) Sequentially list conditions, if eny, laeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants	b	Due to (or es e conse	equence of):	DIOS CUE				orjo.	
	= 0.6	thet initiated evants resulting in deeth) Lest	d	Due to (or es e conse	quence of):						
מ	the deeth cert y the attendin sched for use hysician/N	Pert II. Other significant conditions of	ontributing to death bu	ut not resulting in the	underlying causa gi	iven in Pert I.	23b. Did to	bacco use co	ntribute to t	the cause of death	
7. O	ires that the deeth cert signed by the attending do be detached for use. d by Physician/M						1□ Y	No No	3 ☐ Probe	ably 4 Unknow	
or Vital Records,	aw requisite pension of the second of the se		776				24e. Was e	n eutopsy ned?	com	a eutopsy findings leble prior to pletion of ceuse eeth?	
Ť	The law ate has page 2						1 🗆 Ya	as No	1 🗆	Yes 20 No	
<u> </u>	certificate rector, pag	25. Was cese referred to medicet axaminar?				26. Place of De	ath (Check only on	(e)		3	
>	2 0 0	1 Yes 20 No	Hospitel: 1 ☐ Inpetle	nt 2□ER/Outpatie	ent 3 DOA Ot	her: 4 Nursing I	lome 5 ☐ Reside	ence 6 □Oth	ner (Specify)		
	Attending Phore of death. ector: After the by the funeral iffication:	27. Menner of Deeth Neturel 5 Pending Accident investigatio	28e. Date of Injui (Month, De)	y Year) 28b. Time Injury	Wo	ork? Yes 2 No	28d. Describe ho	ow injury occur	rred		
Division	To the Hospital or Attending Pi within 24 hours after death: within 24 hours after death to the Funeral Director: After it completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ury - At home, farm, s :. (Specify)	treet, factory, office		28f. Location (St City or Town		ber or Rural	Route Number,	
	he Hospital or in 24 hours afte he Funeral Dir pletely filled in edical Cert	29a. Certifier (Check only one) (Check only 2 Madical Exer	ysician: To the best oniner: On the bests of	exemination and or I	th occurred et the ti nvestigetion, in my	ime, date end place opinion, deeth occu	e, end due to tha co pried et the time, d	ause(s) end m ate end placa,	enner es sta end due lo t	ited. the ceuse(s)	
	within 2 To the comple	29b. Signeture and the chapman	2,	1	29c. Licen	se number	2	9d. Date signe	id (Month, D	ay, Year)	
	60	X. L. Ko	nformer		D	1397	1	9/0	190		
,	4	30. Neme end eddress of person who	omplated causa of de	eeth (Item 23a) (Type		011		1			
		Dr. Robert L. K			t 9th Str	eet Fred	erick, Mo	1. 2170	1		
		1									

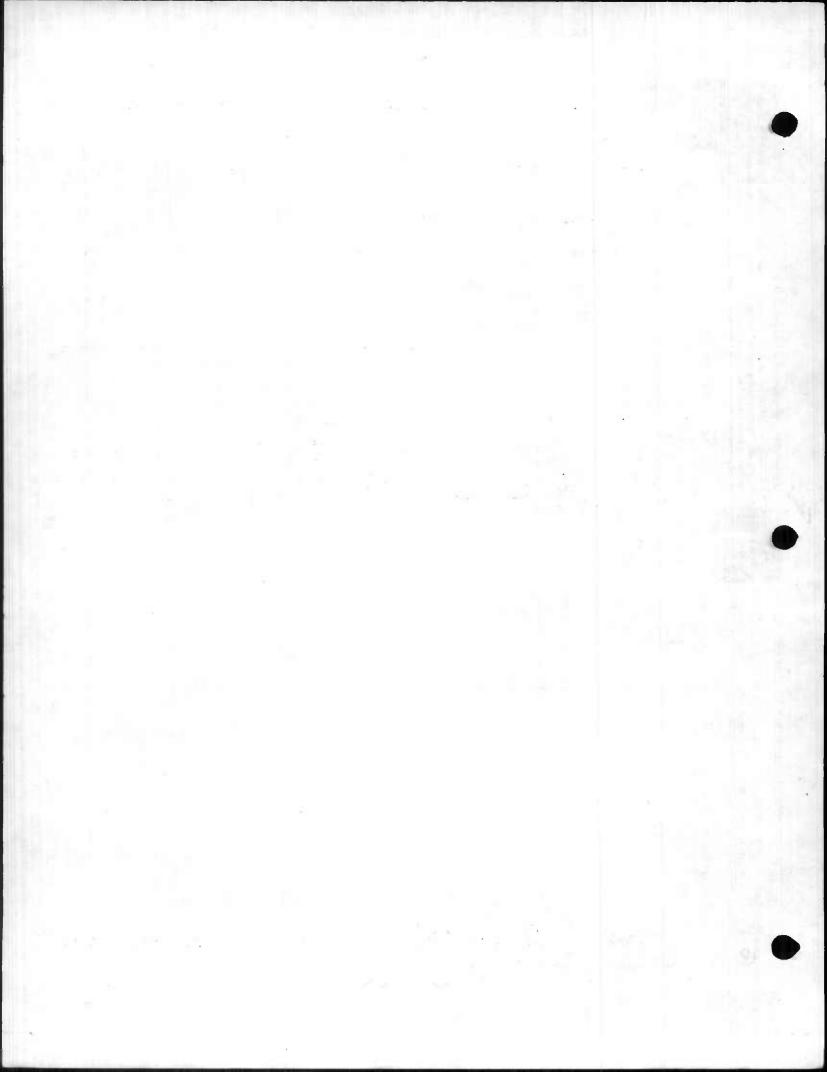
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

				ertificate d	of Death		leg. No. 9	20	010		
Physician	1. Decedent's Name (First, Middle, Li					2. Date of Dea Month	Day	Year	3. Time of Death		
/Medica	Elizab	eth Mary Sher	cidan G	riffin		-	er 9, 1	- 1	1:50 AM		
Examine					4b. City, Town, or I	ocation of Death			- 0-12		
	Manor Care-Potom		- Later	If Under 1 Ye	Potomac Par If Under 24 Hrs.	la but ut bist		gomer	-		
Funeral Director		- C	77s. last birthday 3 Yrs.	Months Da		8. Date of Birth (Month, Day Nov. 18	Year) 1914	9. Birthple Counti De 1	ace (State or Foreign y) IWare		
pue &	10a. State 10b. County	10c.	City, Town or I	Location				10	d. Inside City Limits		
Mary	Maryland Montgo	merv	Rockv	ille					1⊠ Yes 2□ No		
vith the Me s or 28e-f a	10e. Street and Number		110 0111	10f. Zip Cod	e		log. Citizen of V	Vhat Count	y?		
With a second	1433 Fallsmead W	ay		208	54		United	Stat	es		
The state of the s	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	n U,S. 13	I. Was Decedent of Yes, specify C	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yes or No- p Rican, etc.)	14. Rac Blac Specify	e - America ck, White, e	tc.		
2 ho	15. Decedent's E	ducation	16a. Dec	edent's Usual Oc	cupation ne during most of work tired)	l in a	16b. Kind of Bu	siness/Indu	ıstry		
The state of the s	15. Decedent's E (Specify only highest gr	College (1-4or 5+)	4 1 1 1 1			King					
L Martin		3	Regis	stered N			Geriatr		rsing		
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic avant	17. Father's Name (First, Middle, Las				18. Mother's Nam						
Menid Menid						ine Elizabeth Jordan					
Mar 2 sh 1 and 1 am	19a. Informant's Name/Relationship			SE HEID -	eet and Number or Ru						
e, r land theilt m 27 ther i	Joseph Parker Gri		b. Dine of Dine	nasition (Alama	ad Way, Ro		Mary La 20c. Location -	**			
Saltimore, semit. Pages 1 ar Separtment of Heam moortants if flam; in y injury or other Mcs.	1 2 Burial 2 Cremation 3 Donation 5 Other (Special	Removal from State	Cemetery, cri	ematory or other nts Ceme	place)Sept. 1/2 tery	2, 1998	Newark,	Dela	ware		
Departition of the property in page any in page and in page any in page and in	21. Signature Funeral Service Consession (April 1988) Robert A. Pumphrey Funeral Home/Rock 300 West Montgomery Avenue Rockville, Maryland 20850-2805										
Physician	23a Part1. Enter the disease, or con shock, or heeft failure. List only	nplications that caused the d rone cause on each line.	leath. Do not e	nter the mode of	dying, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death		
/Medical	Immediate Cause (Final disease or condition			days							
Examiner	resulting in death)	Sepsis days Due to (or as a consequence of):									
2 = 5		Cell	lulitis	of leg				weeks			
ficate be associted ficate be associated by physician and is the burlat-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):										
		Due to									
at the death cert by the attendin	Death Other elevidions and division			4-4-4	ni ani Dani	anh Dida		-	Ah		
od by the detached	Part II. Other aignificant conditions	contributing to death but not	resulting in the	undenying cause	given in Part I.				the cause of death' ably 4 Unknow		
							98 ZZZ NO	3[]1100	aby 4 onknow		
no uno						24a. Was a perfor		ava	re autopsy findings ilable prior to apletion of cause eath?		
The law ate has b page 2 st						101	es 2 🖾 No	10	Yes 2□ No		
delan: That is certificate he rector, page					26 Place of Dea	ith (Check only o			100 20110		
	1 ☐ Yes 2 ☒ No	Hospital:	2 ER/Outpati	ent 3 DOA	Other	ome 5 Resid		et (Specify)		
oding Physics: After this efuneral diagrams. To		28a. Date of Injury (Month, Day Year		of 28c. I	njury at Work? I □ Yes 2 □ No	28d. Describe h					
be or Attending P as a factor. After the funering of the funer	3 Suicide 6 Could not be determined		281. Location (S City or Tow	itreet and Numb n, State)	per or Rural	Route Number,					
To the Hospital or Attanding Physician 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Centification:	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
withir to the comp	29b. Signature and title of certified 29c. License number 29d. Date signed (Mo								Day, Year)		
	1000 C	And	U		D39456	S	eptembe	r 9,	1998		
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lila T. McConnell, M.D. 2 Wisconsin Circle, Chevy Chase, Maryland 20815										
	21 Date filed (Month Day Your)	, M.D. Z W18 32. Registrar's Si		circie,	Cnevy Cna	se, Mary	Tand 2	0015			
State Registrar	distant a d			1	,						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month 1300 Year GROOMES Low Sept DONNA 98 (1Pm) 4e Facility Neme (If not institution, give street end number) 4h City Town, or Location of Death 4c. County of Death Hospital General Montgomera 5. Social Security Number 3/162 Mont gomer 3 If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1□M 2⊠F ILLINOIS 220 60 2745 44 Yes Usual Residence of Decedent 10a, Stete MD. 10c. City, Town or Location MONROVIA 10d. Inside City Limits FREDERICK 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 12306 FARMFIELD DRIVE 21770 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No If Yes, Give 1□ Yes 20No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE HOSPITAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donald Joseph Rosania Barbara Lee Sowers 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Neme/Reletionship (Type, Print) Donnell A. Groomes, Husband 12306 Farmfield Drive, Monrovia, Md. 21770 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other pla Date 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from Stete Gate of Heaven Cemetery 9/9/98 Silver Spring, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee PRUNE And Andress ARBIER FUNERAL HOME 1 Du P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediete Ceuse (Final 38 pr2 Kespirator diseese or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1□ Yes 2X No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

physician and s the burial-transit certificate be executed

98

signed by t

peen s

certificate

this

To the Hospital or Attanding Physicithin 24 hours after death.

To the Funeral Director: After this of the Attandance of the funeral directors after the funeral directors.

Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

ahow

288-1

the Medical Examiner must be notified at

"natural", or items 23s or

filed within 72 hours after Hygiene. Wher then "neturel", or its

permit. Pages 1 and 2 should be liled. Department of Health and Mental Hygis Important: If Item 27 is marked other: any Injury or other traumatic avent.

Baitimore, Maryland 21215-0020

Director

Funeral

p

Completed

Be

Examiner Physician/Medical by Completed Be Certification: To

25. Wes case referred to medical examiner? 1□ Yes 2⊠No 27. Menner of Deeth 1 Netural 5 ☐ Pending investigation

Hospitel: Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 Yes 2 No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) end menner stated.

29b. Signeture end title of certifier muning

6 ☐ Could not be

29c. License number D19290 29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 1811 Prince Platin Dr. Ohen. CHAPLES R. TUEGELINO

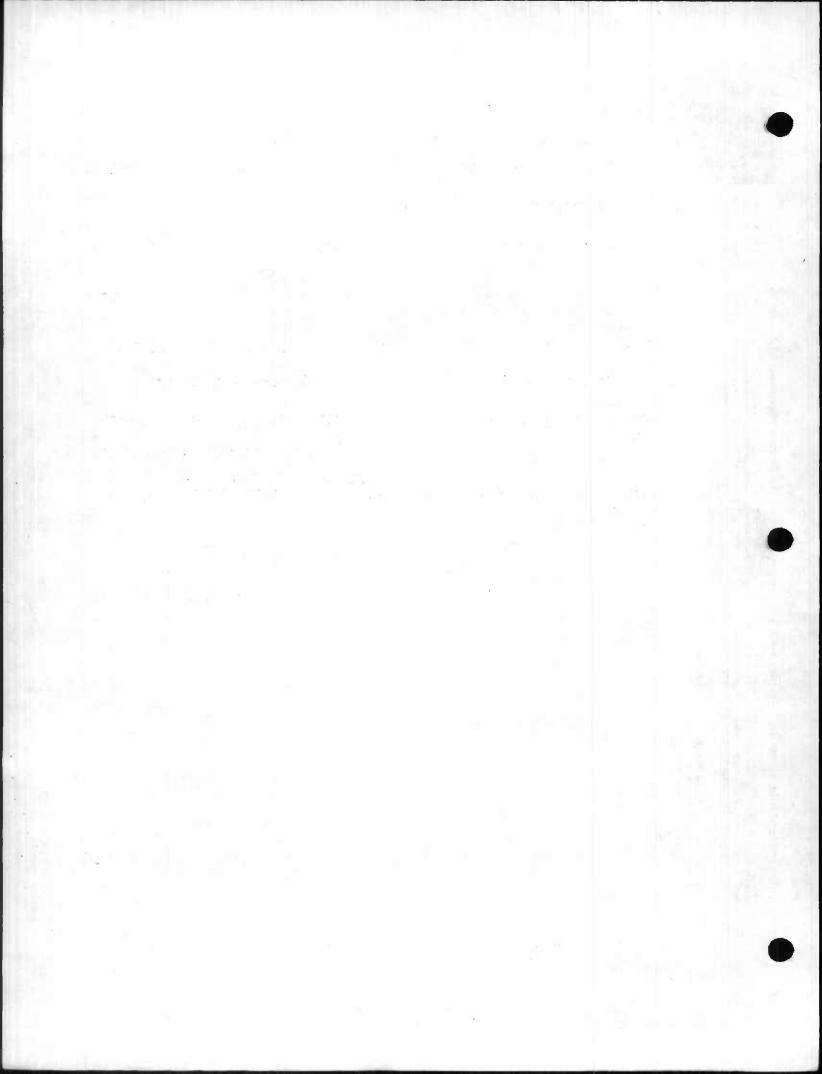
31. Dete filed (Month, Dey, Year)

SEP 08 1998

32. Registrer's Signeture oaks

Registrar

DHMH 16 Ray 6/95



					Ce	rtifica	te of	Death		Reg. No.	200	6
Dhuaisian	1. Decedent's Name (First, I	Middle, Last))						2. Date of Dea	ath Dey	Yeer 3. T	ime of Death
Physician /Medical	TOTAL BUILDING	GROS	S						Septer	nber 12	, 1998 1	0:25 AM
Examiner	4a Facility Name (If not inst			per)					Location of Death			
	VAMC FORT HOW					1 Killada	. d Wass	BALTIM			FIMORE	
Funeral Director	5. Social Security Number 233-34-3625		M 2□F	Age (In yrs.	lest birthday) Yrs.	Months	Days			y, Yeer)	9. Birthplece (Country) MARYLAN	Stete or Foreign
and w	Usual Residence of Decede 10e. Stete 10b. Co			10c. Ci	ty, Town or Lo	ocation					10d. In:	side City Limits
death with the Maryland ms 23a or 28e-f show crount be notified at	IT TTA MO	ORGAN		DAT	V PAW						10	Yes 2 No
officer death with the Mainter death with the Mainter and 126-1 so or 26-1 so	W.VA.			IAV	VIAW	10f. Zi	ip Code			10g. Citizen of	_	7121
th with 23a or	BOX#147 WINCH	HESTER	STREET			2	5434			U.S.	Α.	
	11. Marital Status		12. Wes Decede	ent Ever in U),S. 13.	Was Dece	edent of I	Hispanic Origin? (: an, Mexicen, Pue	Specify Yes or No	14. Rac	ce - American Inc	lian,
D2(02)	3 ☐ Widowed 4 ☐ Dive	-	1 XX es 2 if Yes, Give Yeer or Det	□No		1□ Yes					w: WHITE	
1 21215-00: ed within 72 houn ygiene. or than "natural" it, in Morelle.	15. Dec	edent's Edu	cetion e completed)		16a. Dece	kind of w	ork done	during most of wo	petion during most of working 16b. Kind of			
within then then	Elementery/Secondary (0-		College (1-4	or 5+)	life.	DO NOT	use retire	od)		DATI DO	AT	
other than	12 17. Fether's Name (First, Min	ridio I set)			CSX RA	AILRO	AD T	RAIN DIS	PATCHER me (First, Middle,	RAILRO		
yland build be filed Mentel Hyg arked other attc event,									J. CUNNI			
Marylai d 2 should b th end Ments 7 la marked traumatic e	19e. Informant's Name/Rela		roe. Print)		19b. Maili	na Addres	s (Stree	t end Number or A		Stete, Zip Code)	
Mar nd 2 sho aith end 27 is m	WANDA GROSS			IFE				HESTER ST			W.VA.	
s 1 en f Healt	20a. Method of Disposition				Plece of Disponentery, cre	osition (Ne	other of	ace)	Dete	20c. Location	City or Town, S	tete
0 85 = P	1 Burlal 2 Crema		temovel from St	ate CU	MBERLA	ND CF	REMAT	TORY SEPT	13, 199	8 CUMBE	RLAND M	ARYLAND
프 교통환경	21. Signature of Funerel Se		994 0					ess of Facility				
Depa Impo	1 Tools	7 N	Marin	H				DAMS FUNI JR STREET			VIAND	
	23a. Part1. Enter the disees	e, or compli	icetions thet ceu	ised the dea							Appr	oximate val Between
Physician	shock, or heert tailure.	List only or	ne ceuse on eec	at line.								et and Death
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b st sc			Squamo	us Ce	ll Card	cinon	a Of	Orophar	ynx		Yea	ars
60, be executed loten end bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			Due to (or es a conse	quence of):				1	
, P.O. Box 68760, that the deeth certificate be executed by the ettanding physician and detached for use as the burial-transpondent of the physician Medical Example.	cause. Enter Underlying Ceuse (Disease or Injury that initiated events	2 .	o								1	
6876(ifficate be g physicia es the bur	resulting in death) Last	1		Due to (or as a consec	quence ot)):				-	
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that the deeth comed by the estand detached for us	Part II. Other significant co	nditions con	stributing to deal	th but not rea	culting in the I	nderlying	COURS D	iven in Part I	23h Did	tohacco use co	entributa to the o	ause of death?
P.O. at the at the etache			The state of the s				00000 g				3 Probably	
es tha eigned be de												
Records, ne law requires the law requires the law seen signed ge 2 should be completed by										en eutopsy rmed?	evailable	topsy tindings prior to
The law requires the has been single has been single and completed											of death	on of cause
									10	Yes 2 No	1 ☐ Yes	2 No
Yelden: The securiticate director, pag		-							eth (Check only o	one)		
T die	1 ☐ Yes 2 No	1	lospital: 130 Ing		ER/Outpatie	- 7	JUA		Home 5 Resi			
Jing P. After the funeral	27. Menner of Deeth 1 Matural 5 □ P	ending	28a. Dete of (Month,	Dey Yeer)	28b. Time of Injury		28c. Inju		28d. Describe	how injury occu	rred	
Vision Attending of death. by the fune	2 Accident investigation 3 Suicide 6 Could not be							29f Looption /	Ctraat and Num	har or Pumi Pou	to Number	
Division of the or Attending P are effect death. The distribution of the funeral or	3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)										te Muniper,	
Division To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral Medical Certification	29a. Certifier 1XI Cer	tifvina Phys	sician: To the h	est of my kny	owledge deat	h occurre	d at the t	ime, date and place	e, end due to the	ceuse(s) and m	enner as stated	
ne Hospi n 24 hou ne Funer pletely fil	(Check only 2 Med one)			is of examine				opinion, deeth occ				ceuse(s)
Nithin Fo the	29b. Signature end title of co	ertifier				25	9c. Licen	se number		29d. Date signe	ed (Month, Dey,	Year)
/	1 Alli	ddi	aus/			(751	1493		9/1.	2/98	
6	20 Name and address of no	2000 ubo ao	Aplatadaguas	of dooth (Ita	m (23a) (Tumo	Deint\	اب	. 110		1/10	1.0	

9800 North Point Road Fort Howard, MD 21052

32. Negistrer's Signeture

DHMH 16 Rav 6/95

TOUS

State Registrar Anwer Siddqui, MD

31. Dete filed (Month, Day, Year) SEP 1 4 1998

ELVELOS RIGIS DE CALAMARIA

coulist compared calling

State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Dey Yeer September 7, 1998 **Physician** HELEN DARLENE GRINDER 10:20 AM /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Health Care Center Frederick

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Pay, Year)
Nov. 24, 1930 Iowa 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Deys 535-22-6835 67 Yrs Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location Show 10d. Inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Hear 23 is marked other than "natural", or itema 23a or 28a-f show piy fullury or other treumatic event, in health and it is the properties. Y Yes 2 No Directo Maryland Frederick Frederick 10f. Zlp Code 10g. Citizen of Whet Country? Fred. Health Care Center 30 North Place 21701 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritei Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify. 3 ₩ Widowed 4 Divorced White Completed 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementary/Secondery (0-12) Doctor's Office Medical Assistant 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Lacy Merrill Hayes Bessie Elliott 2 19e. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Tammi Toquinto (Daughter) 5626 Cayne Court, Frederick, Maryland 21703 20b. Plece of Disposition (Name of cemetery, crematory or other placa) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 🖾 Cremetlon 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Smithsburg Crematory 9/8/98 Smithsburg, Maryland 21. Signatule of Funeral S 22. Name end Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 Do not enter the mode of dying, such es cardiac or respiretory errest, Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting In deeth) Examiner Examiner Dirator buriel-transit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Intleted events resulting in deeth) Lest Due to (or as e consequence of): physician at the buriel P.O. Box 68760 ongestive Physician/Medicai Due to (pr es e consequenca of): Por Pert II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yas 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings eveileble prior to page 2 should Completed 24e. Wes en eutopsy peed completion of cause of deeth? cartificate hes 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this cartifica 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To funarai 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 28b. Time of 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homiclde Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end manner steted. 29a, Certifier 29b. Signeture end title of certiff 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) Alan Rohrer, MD 1080 West Patrick Street, Frederick, Maryland 87998 State

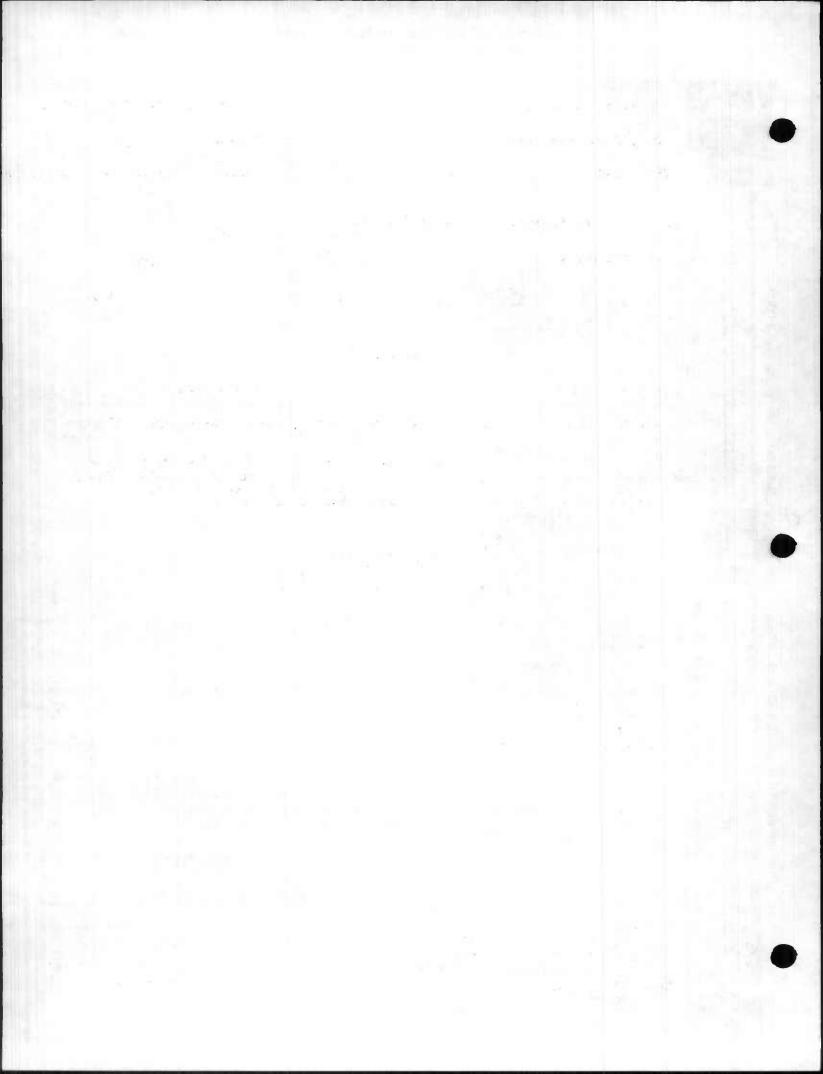
Registrar

5721 K

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death September 9, 1998 **Physician** Walter G. Hardy 3:30 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | Sept. 30, 1926 5. Social Security Number 6 Sax 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** 1⊠M 2□F Yrs. 229-20-3682 71 North Carolina Director Usual Rasidance of Daceden with the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "nature!; or items 23a or 28a-f show traumatic event, the Medical Examiner mant be notified at 1 ☐ Yas 2 No Director Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death 1. Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a any Injury or other traumatic event, the Meuical Examiner must once. 1014 Nora Drive 20904 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Gryas 2 □ No
If Yes, Give
Year or Datas: 1944-45 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Biologist NIH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Garrett Hardy Laura Garner 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Johann Hardy (wife) 1014 Nora Drive, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramoval from Stata Mount Olivet Cemetery 9/12/98 Washington, DC 4 Donation 5 Dother (Specify) of Fungral Servine in 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD even 20901 23a. Paht. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician ardrogens Shock /Medical Immediate Ceuse (Finel sudden diseese or condition resulting in death) Examiner Examiner cardia physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 naketes Physician/Medical Dua to (or as a consequence of): use. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 8 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed complation of causa of death? hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: efter death. Director: After this certific funeral director, 25. Wes case referred to medical examiner? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 \ Homicide To the Hospital within 24 hours e 12 Certifying Physician: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatury and title dispertition 29c. License number 29d. Date signed (Month, Dey, Year) 8+ 090908 Ms SIWER SBOHNU 30. Name and address of berson who completed ceuse of death (Item 23a) (Type, Print) #220 0801 em 32. Registrar's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Physician	
/Medical	
Examiner	

Funeral

Director show 280-1 · Name 23a or 72 hours after "natural", or Hygiens. other than permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If them 27 is marked oth
any injury or other traumatic event

Baltimore, Maryland 21215-0020

Physician /Medical Examine

physician and s the burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed Box 68760 signed by the a P.O. Division of Vitai Records. Completed by pege 2 certificate Be Medical Certification: To this funeral After To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Afte completely filled in by the fun

1. Decedent's Name (First, Middle, Last) Dev Month Ecitabeth HAWKINIS September 6 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSOITAL ROCKVILLE 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Tyrs. | Months | Days | Hours | Min. | Mar. 5, 1931 MONTGOMERY Birthplace (State or Foreign Country) 5. Social Security Number 1 □ M 2 X F 220-26-6754 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location Director MD Montgomery Gaithersburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2 East Deer Park, #104 20877 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2000No If Yes, Give Year or Detes: 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: à **3**€Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Dry Cleaners 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be John Moore Lucy E. McRoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 7 8 19a. informant's Name/Relationship (Type, Print) Wanda Farmer (Step-Daughter) 716 Quince Orchard Blvd., Gaithersburg, 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriai 2 ☐ Cremation 3 ☐ Ramoval from Stata Gate of Heaven Cem. 19/11/98 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice License 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. immediate Cause (Finel Aspiration disease or condition resulting in death) Pheumonia Due to (or as a consequenca of): Examiner VASCUlar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequença of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 kNo 1 ☐ Yes 2 KNo

29d. Date signed (Month, Day, Year)

09/1

10d. Insida City Limits

Approximate interval Between Onset and Death

13 days

13 days

Yas 2 No

25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending

1 Yes 2 No investigation 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and dua to tha causa(s) and menner as statad. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner steted.

29c. License number

oacks

Joseph & BAll mo

29b. Signatura and title of certifier

D0053317 Extember 6 1998

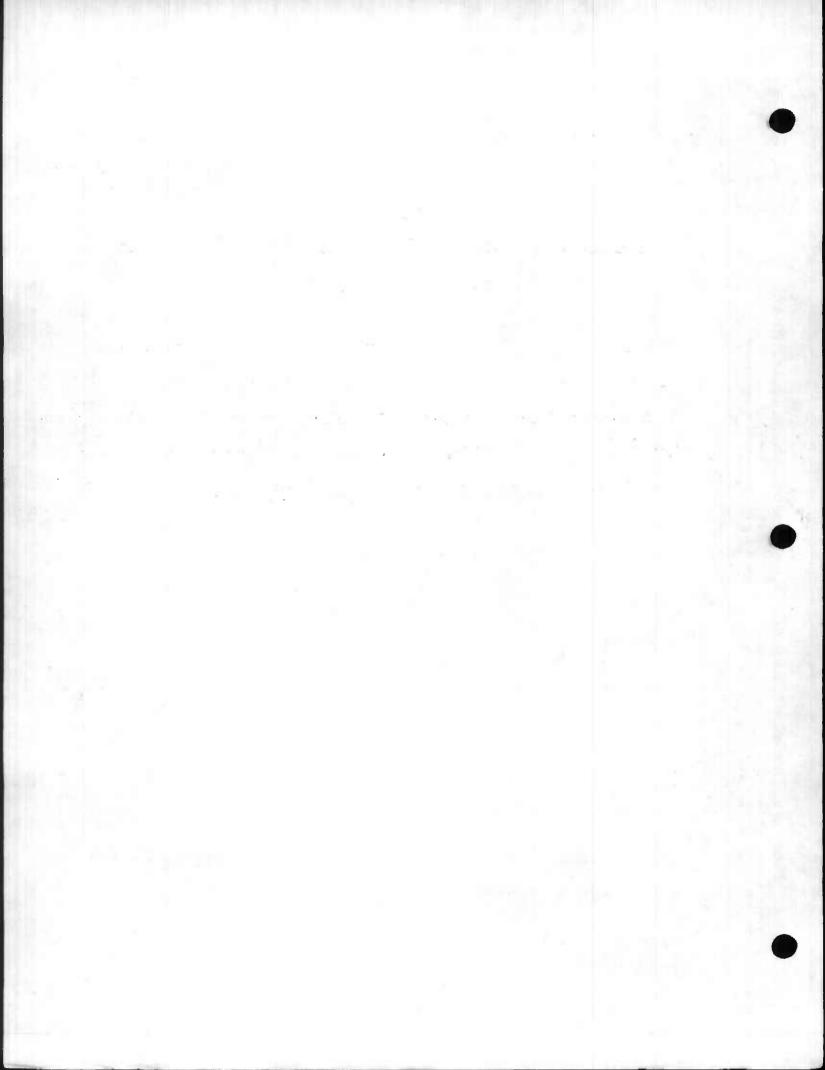
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

JOSEPH ABAI 11501 Georgia AVENUE Suite 515 Wheaton MD

State Registrar

31. Date filed (Month, Dey, Year) 32. Registrar's Signature SEP 1 1 1998

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 29016

Physician
/Medical
Examiner

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Menyland Department of Health and Mental Hygiene. FW Baltimore, Maryland 21215-0020

Phys /Me

To the Hospital or Attending Physician: The law requires that the deeth certificats be executed within 24 hours after death.

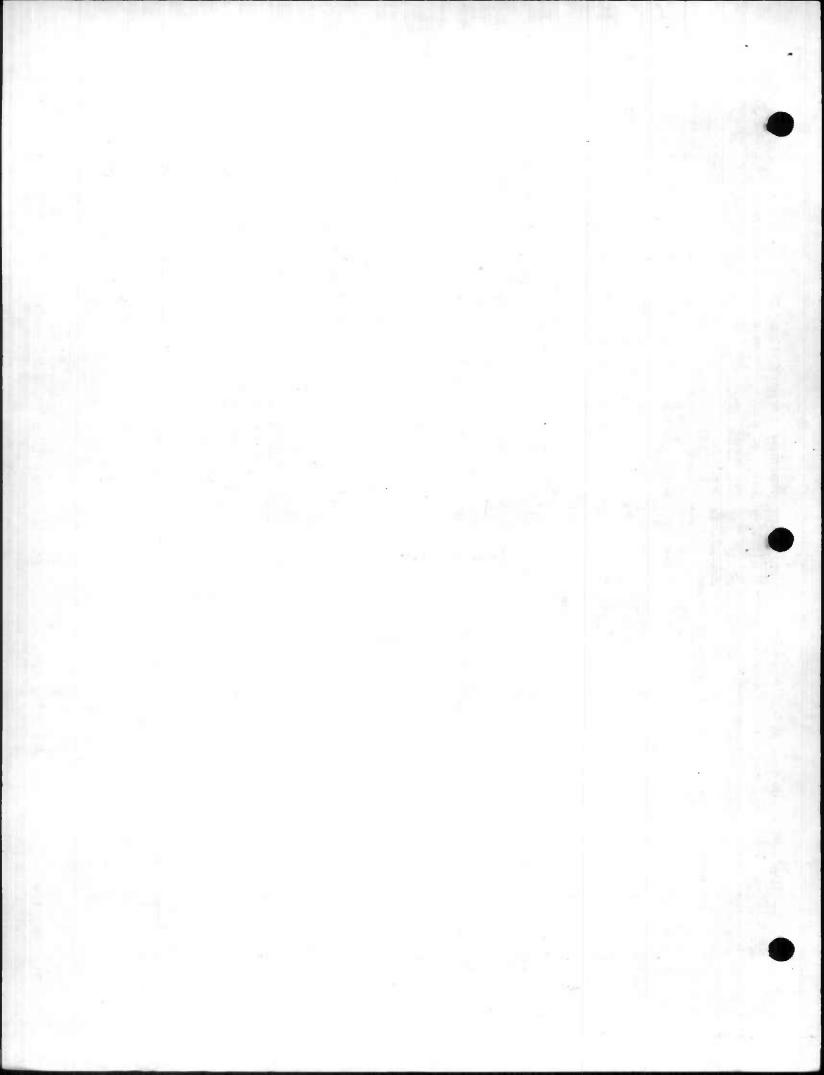
To the Funeral Director After this confined has been accounted.

Division of Vital Records, P.O. Box 68760,

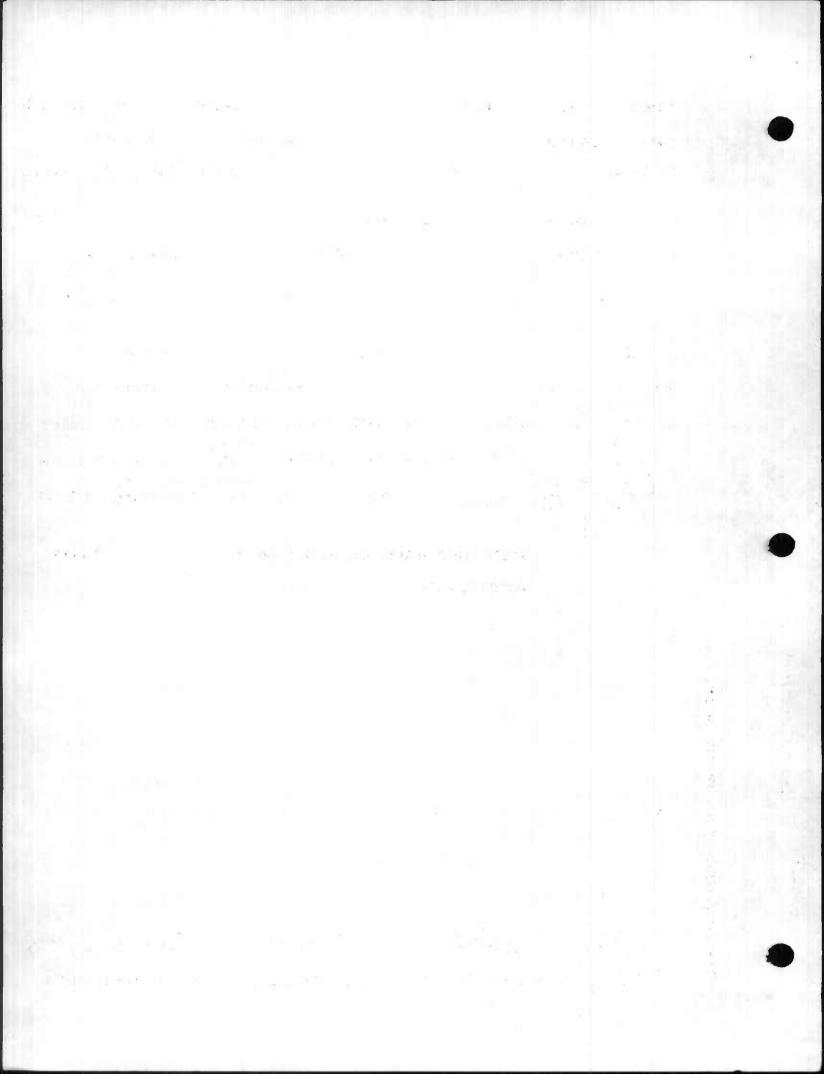
_				-							Reg. No.		
1	1. Decedent's Neme (First, Middle									2. Date of De Month	Dey Year		3. Time of Death
	Robert E. H	ickle								Septem	ber l, l	998	8:00 PM
	4a Facility Neme (If not institution	, give street ar	nd number)					4b. City, To	wn, or Lo	ocation of Deat	h 4c. County	of Death	
ı	5114 Adrian S	treet						Rock	vill	e	Mon	tgome	ery
1	5. Social Security Number	6. Sex		e (In yrs. le	ast birth	day) If Und	der 1 Year is Deys	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ev Year)	9. Birthp	placa (Stete or Foreign
ŀ	496-12-5884	1 X M 2	JF	78	Y	rs.	is Deys	Hours	cviu t.	July 3			linois
	Usual Residence of Decedent												
	10a. Stete 10b. County Maryland Montg	omerv		10c. City,		or Location						1	10d. Inside City Limits 1 ☐ Yes 2 🖔 No
t	10a. Street and Number					10f. 2	Zip Code				10g. Citizen of V	What Cour	ntry?
1	5114 Adrian St	reet					2085	3			United States		
ŀ	11, Meritel Stetus	12. Was	Decedent B	Ever in U,S	S.	13. Was Dec	cedent of h	lispanic Ori	gin? (Sp	cify Yes or No-			can Indien,
ı	1 Never Merried 2 Merri		ed Forces? Yes 2 ☐ N es, Give	Wor1	14					Rican, etc.)	Bled	etc.	
	3 ☐ Widowed 4 Divorced	If Yee	es, Give r or Detes:	War	II	1□ Yes	2 (Z) No	Specify:			Specify	Specify: White	
	15. Decedent	's Education			16a. C	Decedent's Us	suel Occur	cupation 16b. Kind of But					
	(Specify only highes	it grade comple			(Give kind of v life. DO NOT	work done use retire	roupation from the distribution of the distrib					
	Elementery/Secondery (0-12)	Colle	ege (1-4or 5 4	+)				ficer United Stat					es Navv
1	17. Father's Name (First, Middle,	Last)	1			Maval	OLLI	18. Mother's Name (First, Middle, Maiden Surneme)					ics havy
1	Glen C. Hickle									Murphy			
19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number Daniel R. Hickle/Son 208 North Main Str													
	Daniel R. Hickl	e/Son						in St	reet	, Woods			
1	20a. Method of Disposition 1 Description 24 Cremetion	2 Dameural	Anna Ctata	20b. Ple	ece of E metery,	Disposition (A , cremetory o	Verne of or other ple						own, Stete
1	4 Donetion 5 Other (Se		from State					atorium, Inc. Bethesda, Mary					Marvland
-	21. Signature of Funerel Service I	Licensee							Fecility Robert A. Pumphrey Funeral H				
Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805												venue	
	23a. Part1. Enter the disease, or shock, or heart feilure. List	complications only one cause	e on eech lin	the deeth.	. Do no	ot enter the m	ode of dyi	ng, such es				1 1	Approximete Intervel Between Onset end Deeth
	Immediate Ceuse (Final disease or condition resulting in death)	complications only one cause a	Hepat	the deeth. Oce11 Due to (or	lula	ot enter the m	ode of dying in one of the office of the off	ng, such es				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Intervel Between
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DHMH 16 Rev 6/95

State Registrar



				Cei	rtifica	te of	Death			Reg. No.		
	1. Decedent's Nama (First, Middla	Last)						2	2. Date of De	eath	Yeer	3. Tima of Death
hysician /Medical	TIMOTHY E.	Н	OLT					S	EPTEM	BER 3,	1998	9:10 P.M.
xaminer	4a Facility Name (If not Institution,	give street and nur	nber)			4	b. City, Tow				ty of Death	1
	SUBURBAN HOSPIT	AL						IESDA		MON'	TGOME	
neral		6. Sax 1 ☑ M 2 ☐ F	7. Age (In yrs. las		If Unde Months	Days	If Under 2 Hours	Min.	Month, D	ev. Year)	9. Birth	place (Stete or Foreign intry)
ctor	219-74-4567	X	35	Yrs.					Feb l	4, 1963	Wash	ington, DC
	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
5		omo wu		bin J								1 ☐ Yes 2 ☐ No
by Funeral Director	Maryland Montg	omery	Ca	IDIII 3	7	p Code				10g. Citizen o	f What Cou	A
ā	6522 77th Stree	-				2081	Q			United		
Funeral	11. Marital Status		dent Evar in U.S.	113.1				in? (Speci	ify Yas or N			icen Indian,
E	1 Never Married 2 Marrie	Armed Fo	rces?	10.1	Yes, spe	cify Cuba	lispanic Orig an, Mexican,	Puerto Ri	ican, etc.)	Bi	ack, Whita	
by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Giv Yaar or Da	9		1 Yes	2 🗓 No	Specify:			Spec	ite	
P	15. Decedent			16a. Deced	dent's Usu	al Occup	ation			16b. Kind of Business/Industry		
Completed	(Specify only highest	grede complated)		(Give	(Give kind of work done during most of work lite. DO NOT use retired)			of working	king			
ompleted	Etementary/Secondary (0-12)	College (1	-4015+)		Clerk						cery	
BeC	17. Father's Name (First, Middle, L	ast)		18. Mother's Name					First, Middle	, Meiden Sume	eme)	
ToB	Homer S. E.	Holt , Jr		Nunziati					na	Vi	cecon	te
-	19a. informant's Name/Relationsh		Nunziatina 19b. Mailing Address (Street end Number or Rurel Rout					Route Numl	ber, City or Tow	n, Stete, Z	ip Code)	
	Nunziatina Holt		6522	77th	Str	eet, (Cabin	John	, MD 2	0818		
To Be C	20a. Method of Disposition	20b. Pla	ce of Disponetery, crer				1	Date	20c. Location		Town, State	
	180 Burial 2 Cremation 4 Doubtion 5 Other (Sp	3 Removal from	DOMES	_			Park		pt 8,	Poolerri	110	Marriand
4	21. Signature of Funeral Sepree L	1	Idir									Maryland
	22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877											
	makey 1	n. /	augad the death								urg,	Approximate
	23a. Part. Enter the disease, or o shock, or heart failure. List of	nly one cause on e	ech line.	DO HOL BIN	er the mo	de oi dyii	ig, auon ea c	Jordiac or	103pilatory 1	a1100t,	1	Intervat Between Onset and Death
ian . cal	Immediate Cause (Final											
ner	disease or condition resulting in death)	a. ACUTE	UPPER C	SASTRO	DINTE	STIN	AL BLI	EEDIN	iG .			3 DAYS
1			Due to (or a		quence of)):						
Examiner		b. DUODE	NAL ULCE	ER								
XBZ	Sequentially list conditions, if any, leading to immediate ceusa. Enter Undarlying Ceuse (Disaase or Injury that initiated events	45.5	Due to (or e	s a consec	quence of)	ř.						
al El	ceusa. Enter Undarlying Ceuse (Disaase or Injury	C									i	
E.*	resulting in death) Lest		Due to (or a	s a conseq	uence of)						į	
Z E		d,										
AYLE, Physician											1	
MAYI.E	Part II. Other eignificant condition	s contributing to de	eath but not result	ing in tha u	ndarlying	ceusa giv	sa givan in Pert I. 23b. D			23b. Did tobacco use contributs to the c		to the cause of death?
AAYLE,									10) Yee 2 No	3 Pr	obably 4 Unknown
2 - 2									14/		045 1	Mara autonov findina
FRANCIS										s en eutopsy formad?	а	Were eutopsy findings available prior to completion of ceuse
FRANCI												of deeth?
FRA									1 🗆	Yes 2 No	1	I ☐ Yes 2 ☐ No
Be Be	25. Was cese referred to medical axaminer?						26. Place	of Death	(Check only	one)		
DR	1 X Yes 2 No	Hospital: 1 🗆 I	npatient 2 X El	R/Outpatier	nt 3 D	OA Oth	ier: 4 🗆 Nur	rsing Hom	e 5 Res	sidence 6 🗆 C	thar (Spec	cify)
	27. Menner of Death	28a. Data o	of Injury 2 th, Dey Year)	8b. Time of	1	28c. tnjur Wor	y at	28	3d. Describe	how injury occ	urred	
BY	1 Natural 5 Pending 2 Accident investig		., ,	,,	М		Yes 2 N	No				
EASED Certific	3 Suicide 6 Could no determine	and 288. Place	of Injury - At hom	e, farm, str	reet, facto	ry, office		28	Bf. Location	(Street end Nui	mber or Ru	rel Route Number,
Certification:	- Controlle	Duiloit	ng, etc. (Specify)						J., 01 1	, 5.0.0/		
73 78		Physician: To the										
REL.	(Check only 2 Medical E	xaminar: On the ba and mann	asis of examinatio ner stated.	n and/or in	vestigatio	n, in my o	pinion, deat	th occurred	d et the time	, date and plac	a, and due	to the ceuse(s)
	29b. Signature and title of certifiar	> 6	1		29	c. Licens	a number	1 00		29d. Data sig	ned (Month	h, Day, Year)
I.R.	Dame	m Ku	m			D	474	+99		DO	ember	-3,1998
E	30. Name end eddress of person w	ho completed caus	e of death (Item 2	3a) (Type	Print)							
*CLEARED	BARRY N	1. KBIN	1 101			S MI	LL ROA	AD.	WHEAT	ON, MAR	YLAND	20906
State	31. Date fited (Month, Day, Year)	32. B	egistrer's Signatu		-			,				
gistrar	SEP 0 8 19		epera	19.	do	aks	1					
•	OLI OUI	100			//	Man						



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Data of Daath 1. Decadant's Nama (First, Middla, Last) SEPTEMBER 6 HYACINTH 4:25 AM HU 611 1998 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Undar 24 Hrs. Hours Min. if Undar 1 Yaar 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) Days Months 1 M 25 F Yrs. 213-76-3457 76 Dec. 3,1921 Jamaica Usuel Rasidence of Decedent 10a. Siata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☑ No Gaithersburg Maryland | Montgomery 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 20041 Doolittle Street 20879 14. Race - Amaricen Indian, 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify: Other 3 ☐ Widowed 4 ☑ Divorced White Arawack Indian 15. Decedant's Education (Spacify only highast grada complated) 16a. Dacedani's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 Accounting Clerk Pepco 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Reginald Byndloss Lucille I. Marshall 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 20041 Doolittle Street Gaithersburg, Maryland Carole N. Chew (daughter) 20b. Plece of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☑ Bunial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Spacify) 9/11/98Silver Spring, Maryland Gate of Heaven Cemetery 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 20901 Part1. Enlar tha diseasa, or completely is that causad the shock, or heart failura. List only one Approximata Injarval Batween Onsat and Death Lower Extremity Immediata Causa (Final disaesa or condition rasulting in death) 3 weeks Jany use Dua to (orus a consequance of): Sequantially list conditions, if any, leading to immadiata ceusa. Enter Underlying Ceuse (Diseasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consaguance of): Dua to (or as a consequance of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Unknown 1 Yes 2 No 3 Probably 24b. Ware eutopsy findings available prior to 24a. Was an autopsy performed? complation of causa of death? 25. Was cesa rafarrad to medicel axaminar? 26. Placa of Daath (Chack only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Impatiant 2 ER/Outpatient 3 DOA 28d. Dascribe how injury occurred 27. Menner of Death 28b. Tima of 28c. Injury el Work? 1 Neturel 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be detarmined 3 Suicida 28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

physician end the buriel-transit certificate be executed ivision of Vital Records, P.O. Box 68760, ettending p for use es 98 by the e 3 signed t been sig page 2 s certificete director, S After the Funersi Director: Aft ŏ within 2

9/6/98 4:15 Am

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Baltimore, Maryland 21215-0020

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signatura and titla of certifier

29c. Licansa number

29d. Data signed (Month, Day, Year)

D37891

SEPTEMBER 6, 1998

30. Nama and eddress of person who complated causa of death (Item 23a) (Type, Print)

A.RAJVANYHI MD 121 Wygressworal Ln #409 Recknille mo 20852

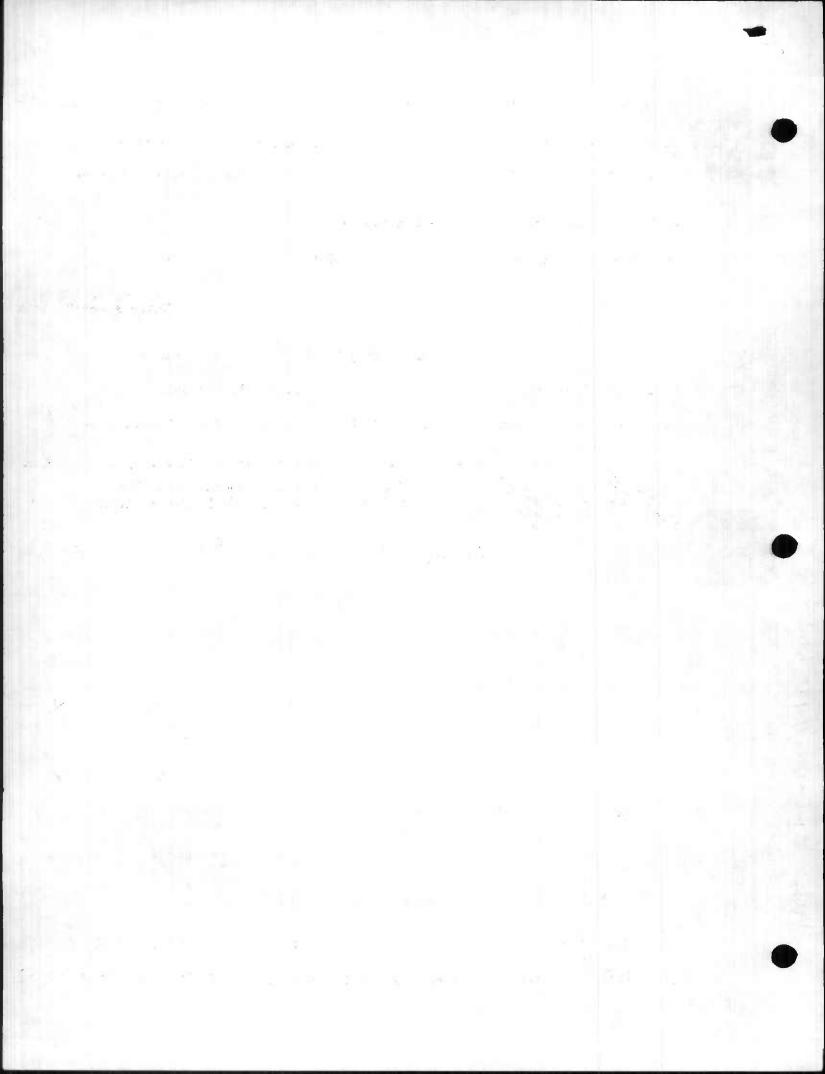
Registrar

31. Date filed (Month, Day, Yaer)

SEP 1 0 1998

32. Registrar's Signatura

0



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Deeth 3. Tima of Death Day Month Vaar SEPTEMBER 6, 1998 2015 Wilson Ward Harvey 4b. City, Town, or Location of Death 4a Fecility Nema (If not Institution, give street and number) 4c. County of Death Cumberland **Allegany** Sacred Heart Hospital Il Undar 1 Year | If Undar 24 Hrs. 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) 1□M 2□F Days Yrs 89 236-58-3856 Aug. 18, 1909 Maryland Usual Rasidanca of Deceden 10c. City, Town or Location 10d. Inslda City Limits 10a Steta 10b. County 1 Yas 2 No Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 107 Orchard Street 26726 U.S.A. 12. Was Decedant Ever in U.S. Armed Forcas? 11/2 Yas 2 No It Yas, Give Yaar or Dates: WW II 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Stetus Bleck, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2√ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) Elementary/Secondary (0-12) Collega (1-4or 5+) Minister Ministry 18 Mothar's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) C. Guy Harvey Dessa Callis 19a. Informant's Name/Raletlonship (Typa, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) 107 Orchard Street, Keyser, WV 26726 Bonnie N. Harvey (Wife) 20b. Place of Disposition (Nama of cematery, crematory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 □ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Spacify) Woodsdale Mem. Gardens 9/10/98 Grafton, WV 21. Signatura # Funarai Sarvica Licansee 22. Nama and Addrass of Fecility Markwood Funeral Home 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cardiac or respiratory errest, shock, or heer feilure. List only one cause on each line. Approximete Intarval Between Onset and Death Immadiata Causa (Final diseasa or condition resulting in deeth) · Cardiogenic Shock Dua to (or as a consequence of): ald. Dustra NO 1212 9 Dua to (or as a consequence of). Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Wes an autopsy performed? completion of causa of death? 1 Yas 2 No 1☐Yes 2☐No 25. Was case rafarrad to madical 26. Piece of Death (Chack only ona) Hospital: 1 □ Impatiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding Invastigation 1 Yas 2 No

Examiner ig physicien end es the buriel-transit The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760. ettending use ed by the e should I is certificate has b director, page 2 st Hospital or Attanding Physician: this death. Director: / To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b

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permit. Pages 1 end 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature."

Physician/Medical Examiner p Completed Be To Certification: edical

1 Yas 2 No 27. Manner of Deeth 1 Watural 2 Accidant 3 Suicida 4 Homicide

29a, Certifier

State Registrar

29b. Signetuse end titla of cartilier

6 Could not be

29c. Licansa number

1 Certifying Physician: To the bast of my knowledga, daath occurred at the time, date and placa, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

umberland MD 21502

281. Location (Streat and Number or Rural Route Number, City or Town, Stata)

30. Name and

SEPTEMBER 1998

awa of daath (Ham 23a) (Type, Print) 915 Seton Drive

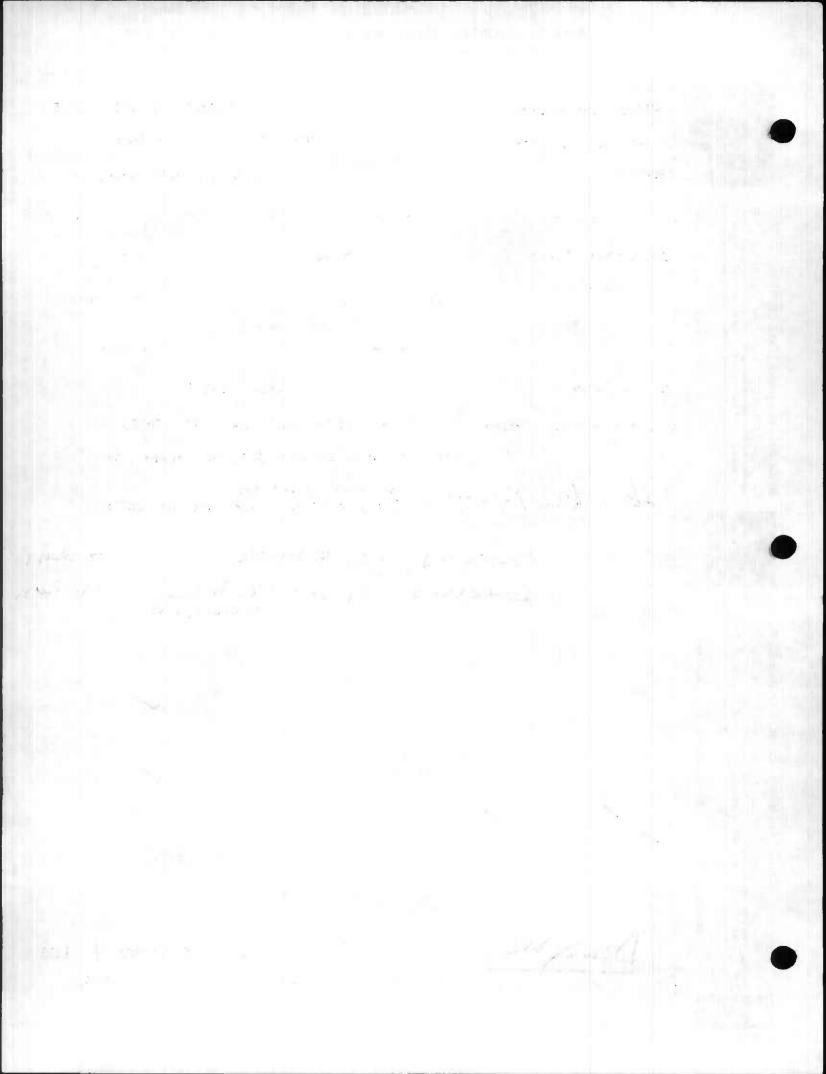
,M.D Sivar filla

31. Data filed (Month, Day, Year) 32. Registrer's Signatura

SEP 0 9 1998



28a. Placa of Injury - At home, farm, straet, factory, offica building, atc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Sep 7, **Physician** Yaar 1998 11:30 a.m. Bessie Marie Hare /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Devlin Manor Nursing Home Allegany Cumberland If Undar 24 Hrs. 5. Social Sacurity Number 6. Sex If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) 8. Data of Birth **Funeral** 10 M XD F Months Days Hours Min Yrs. Director MD 81 219-14-6489 Jul 18, Usual Rasidance of Dacadant with the Marylend 10a. Stata tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, in a Madical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Insida City Limits Director Y□ Yas 2□ No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 135 N. Mechanic Street 21502 death USA 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No if Yas, specify Cuban, Mexican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. hours efter 1 ☐ Yas X☐ No If Yas, Give Yaar or Datas: 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas X□ No Specify: p Specify Nidowed 4 ☐ Divorced white Completed 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decadant's Education (Spacify only highast grade complated) 16b. Kind of Businass/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Depertment of Health and Mental Hygien Important: If Itam 27 is marked other than any Injury or other traumetre Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Be Walter J. Trout Alice Virginia (Robinette) 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Donna Garland-daughter 8004 Cuba Drive Pasadena MD 21122 20a. Mathod of Disposition 20b. Placa of Disposition (Name of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 1 Buriai 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Sunset Memorial Park 09/10 Cumberland MD 21. Signatura of Funeral Sarvice Licenses 22. Nama and Addrass of Facility Scarpelli Funeral Home, P.A. Cumberland MD 21502 23a. Part1. Entar the disease, or compilications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata intarval Batween Onsat and Death **Physician** immadiata Causa (Final disaase or condition rasulting in deeth) /Medical Examiner Due to (or as a consequanca of) Examine nding physician end use as the bunel-transit The lew requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiata ceuse. Enter Undarlying Cause (Disease or injury that injury that injury that injury Dua to (or as a consaquance of): Box 68760 Physician/Medical that initiated avents resulting in death) Last Dua to (or as a consequence of): ettending | for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by the P No 1 Yes 3 Probably 4 □ Unknown Records, þ cate hes been significant pege 2 should b 24b. Wara autopsy findings availabla prior to complation of ceusa of daath? Completed 24a. Was an autopsy performed? certificate 1 Yas No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was cesa ratarrad to madicei axaminar 1 ☐ Yas No director. Be 26. Place of Death (Check only one) Othar: Aursing Homa 5 Rasidance 6 Othar (Specify) 2 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Magnar of Death 28a. Data of injury (Month, Day Year) 28c. injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred After To the Hospital or Automotion 24 hours after death.

To the Funeral Director: Aft Neturai 5 Panding Invastigation 1 ☐ Yas 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicida Medical Conting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the causa(s) and manner stated. 29a. Cartifier one 29b. Signi ext certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D12779 30. Name and address of person was completed cause of death (Item 23a) (Type, Print)

500 Memorial Avenue Cumberland MD 21502

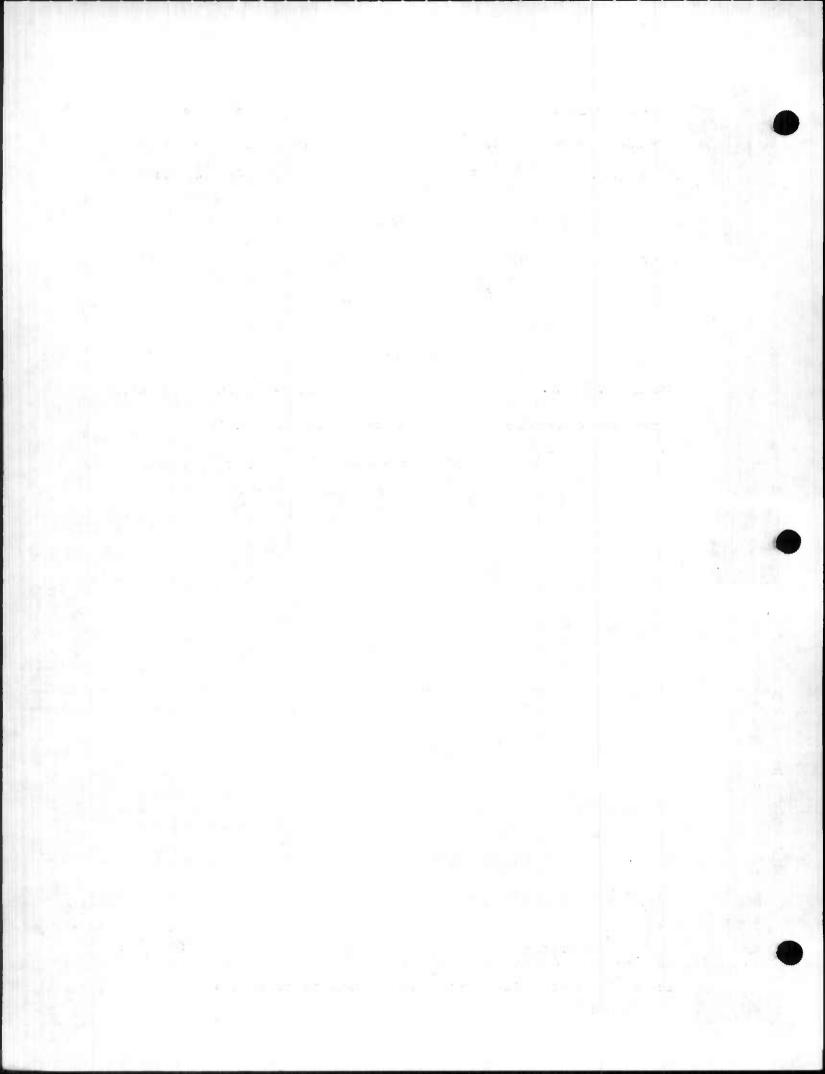
32' Ragistrar's Signetura

Registrar

State

Dr. W. Guy Fiscus
31. Data filed (Month, Day, Year)

SEP 0 8 1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth September 6, 1998 **Physician** Mariorie Hoopengardner 1:25 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner Frederick Frederick Frederick Memorial Hospital if Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Devs Hours Min. (Month, Dev, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1□M 2□F Months Deys 578-30-5266 70 Feb 27 1928 Missouri Director Usuei Residence of Decedent 10c. City. Town or Location 10a Stete 10d. Inside City Limits the Marylend 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Mod cal Examiner mant be notified at 1 ☐ Yes 2 ☐ No MD Frederick Director Brunswick 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 119 Ninth Avenue USA 21716 Funeral deeth 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes ②☐ No
If Yes, Give
Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Introcrant: If tem 27 is merked other than "natural", or fee any Injury or other traumatic avant. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3€Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Geographic Elementery/Secondery (0-12) College (1-4or 5+) Employee Society 10 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Floyd Wayne Coopen, Sn. Velma Manganet Porter 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donis Handing 603 Ninth Avenue, Brunswick, MD 21716 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 DeBuriei 2 ☐ Cremetion 3 ☐ Removel from State Pank Heights Cemetery 9/9 4 ☐ Donation 5 ☐ Other (Specify) Brunswick, of Funder I Service Licensee

Williams, 21. Signetyre of Funeral Service 22. Nome and Address of Facility

John T. Williams Funeral Home

100 Petersville Rd Brunswick MD 21716 Owner 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest shock, or heart failure. List only one cause on each line. Physician Immediate Ceuse (Finel disease or condition resulting in death) Presmanu /Medical luk Examiner Due to (or es e consequence of): Examiner Emphy dema physician end s the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (of es e consequence of): requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 950 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 12 Yes 2 No 3 Probably 4 Unknown carcinoma brias þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en autopsy Completed 1 Yes 2 No 1 Tyes 2 No after death.

Director: After this certifications funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No impetient 2 ER/Outpatient 3 DOA Certification: To 28c. injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Naturei 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral DI edical Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier MD D09689 30. Neme and eddress of person who completed cause of deeth-(flem 23e) (Type, Print) 9th Street, Frederick, MD Peanne, MD. Austin A. 300 W. 31. Date filed (Month, Dey, Year) SEP 0 9 1998 32. Projetrer's Signature State

DHMH 16 Rev 6/95

Registrar

LO TO THE SECOND OF THE PROPERTY.

State of Maryland / Department of Health and Mental Hygiene 0 0 0 0 0 0

-icion				Cer	tificate of	t Death		Reg. No.		E-104 WHO			
	1. Decedent's Neme (First, Midd	fle, Last)					2. Date of Month	Deeth Dey	Yeer 3.	Time of Deeth			
sician edical	R	ichard	Le	wis	Но	ffman St	. Septe			:50 AM			
miner	4e Facility Neme (If not institution		ber)			4b. City, Town, o	r Location of De	eath 4c. County	of Deeth				
	Frederick Memorial				WILL A VI	Freder		Frede					
ral tor	5. Social Security Number 217–12–2853	6. Sex 1 1 M 2 □ F	7. Age (In yrs.	lasf birthday) Yrs.	If Under 1 Year Months Day		n (Magneth	8, 1924	9. Birthplece (Country) M.	Stete or Foreig			
	Usual Residence of Decedent 10a. Stete 10b. County	w	10c C	ty, Town or Lo	cation				10d In	side City Limits			
5										☐ Yes 2 ☑ No			
Director	Md. Freder	LICK	1	rederick	10f. Zip Code			10g. Citizen of V	What Country?				
by Funeral Director	5776 Old National	l Pike				21701		U.S.	Α.				
by Funeral	11. Maritel Status 1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	12. Was Dece Armed For rried 1 57 Yes If Yes, Give d Yeer or Da	ces? 2 □ No W.	V. 13. V	Vas Decedent o I Yes, specify Cu □ Yes 2√2 N	f Hispenic Origin? uban, Mexican, Pu o Specify:	(Specify Yes or erto Rican, etc.)	Bled	a - American Ind k, White, etc. White	dien,			
Completed	15. Deceder (Specify only higher	nt's Education est grede completed)		16a. Deced	ent's Usual Occ	ne during most of w	vorking	16b. Kind of Bu	usiness/Industry				
du	Elementery/Secondary (0-12)	College (1-	4or 5+)		OO NOT use reti	red)		comont	00				
	8	(scaler	aster	10 Mathada N	lama /First Mid	dle, Maiden Sumen					
To Be	17. Father's Neme (First, Middle, Lewis N. Hoffman	, Last)					• Zinnem		10)				
	19e. Informent's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Stre	ef end Number or	Rurel Route Nu	mber, City or Town,	Stete, Zip Code)			
To	Charloote E. Hoffin	man (Wife)		5776 C	ld Nation	al Pike, F		MH. 21701					
once.	20e. Method of Disposition 1 Burial 2 □ Cremetion 4 □ Donation 5 □ Other (5		tate	cametery, cren	sition (Neme of netory or other p		9/5	Frederic	City or Town, S	itate			
	21. Signature of Funeral Service	cicensee		22	Name end Add	dress of Facility			1110				
8	21. Signature of Funeral Service ticensee 22. Name end Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Ml. 21769 23e. Parti. Enter the disease, or complete ions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one sause on each line.												
	23e. Part1. Enter the disease, o	or complications that ca	used the dea	th. Do not ente	or the mode of d	lying, such es card	iec or respiretor	y arrest,	Appi	roximete			
n I	snock, or neart failure. Lis	only one cause on ea	ich line.						Ons	vat Between et end Deeth			
al	tmmediate Cause (Finat disease or condition	- 1	1/10	nen	nin				121	4/10			
r	resulting in death)	e	Due to (or as e conseq	uence of):					///			
Je J		4.4											
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or es a conseq	uence of):								
a E	Ceuse (Disease or Injury	c							i				
edical	thet Initieted events resulting In death) Last		Due to (or es a conseq	uence of):				İ				
Physician/Medical Examir		d											
Icla	Part II. Other eignificent conditi	lone contributing to de	ath but not re	sulting in the ur	nderlying cause	given in Part I	23b. I	Old tobacco uee co	ntribute to the	causa of death			
hys	/ attit. Other eignincent conditi		1-1	11	luenying cause	givoir ii r uit r.		□ Y00 2 10 No		4 □ Unknow			
by P	Upper Dus	annes	ed	ece	dez		-						
ed by Physic	0.11.	+			/			Vas en eutopsy erformed?	24b. Were at	utopsy findings prior to			
Completed	Cenzana	un				J. Say	- "	onominos.		ion of cause			
E	-						1	Yes 20 No	1 ☐ Yes	2□ No			
13	25. Was case referred to medica	al				26. Piece of D	Death (Check or	nly one)					
	exeminer?	Hospital:/	patient 2	ER/Outpetien	t 3D DOA	Other		lesidenca 6 Oth	er (Specify)				
Be				28b. Time of		njury at Vork?		be how injury occur					
To Be	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o		Injury		Vork? ☐ Yes 2 ☐ No							
To Be	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Naturel 5 ☐ Pendi		i, Dey Year)										
To Be	1 Yes 2 2 No 27. Manner of Death 1 Waturel 5 Pendi 2 Accident invest 3 Suicide 6 Could	tigation I not be		nome, farm, str ify)	eet, factory, offic	> 8	28f. Location City or	on (Street end Numb Town, State)	per or Rural Rou	ite Number,			
Certification: To Be	27. Manner of Death 1	d not be mined 28e. Placa building Physician: To the t Examiner: On the ba	of Injury - At I g, etc. (Spec best of my kn sis of examin	ify) owledge, deeth	occurred at the	time, date end ple	City or	Town, State) the cause(s) and ma	anner es steted				
edical Certification: To Be	27. Manner of Death 1	In not be mined 28e. Placa buildir ing Physician: To the t Examiner: On the ba and mann	of Injury - At I g, etc. (Spec best of my kn sis of examin	ify) owledge, deeth	occurred at the	time, date end ple y oplnion, death oc	City or	Town, State) the cause(s) and mane, dete and ptaca,	anner es steted. end due to the	ceuse(s)			
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edical Certification: To Be	27. Manner of Death 1 Maturel 2 Accident 3 Suicide 4 Homloide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person	ing Physician: To the t Examiner: On the band mann	of Injury - At Ing., etc. (Special Special Spe	owledge, deethetion and/or inv	occurred at the restigation, in m	o time, date end ple y opinion, death of ense number	City or	the cause(s) and mme, dete and placa,	anner es steted, end due to the d (Month, Dey,	ceuse(s) Year)			
fleation: To Be	1 Yes 2 No 27. Manner of Death 1 Whaturel 2 Accident 3 Suicide 4 Homlolde 29a. Certifier (Check only one) 29b. Signature and Jitte of certifier	d not be and building Physician: To the texaminer: On the ba and mannier. In who completed cause the cause the completed cause the cause the cause the cause the caus	of Injury - At Ing., etc. (Special Special Spe	owledge, deethetion and/or inv	occurred at the restigation, in m	o time, date end ple y opinion, death of ense number	City or	Town, State) the cause(s) and mane, dete and ptaca,	anner es steted, end due to the d (Month, Dey,	ceuse(s) Year)			

BALTIMORE, MARYLAND 21215-0020 for death. Page 6 may be retained by the hospital or attending obsercian

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

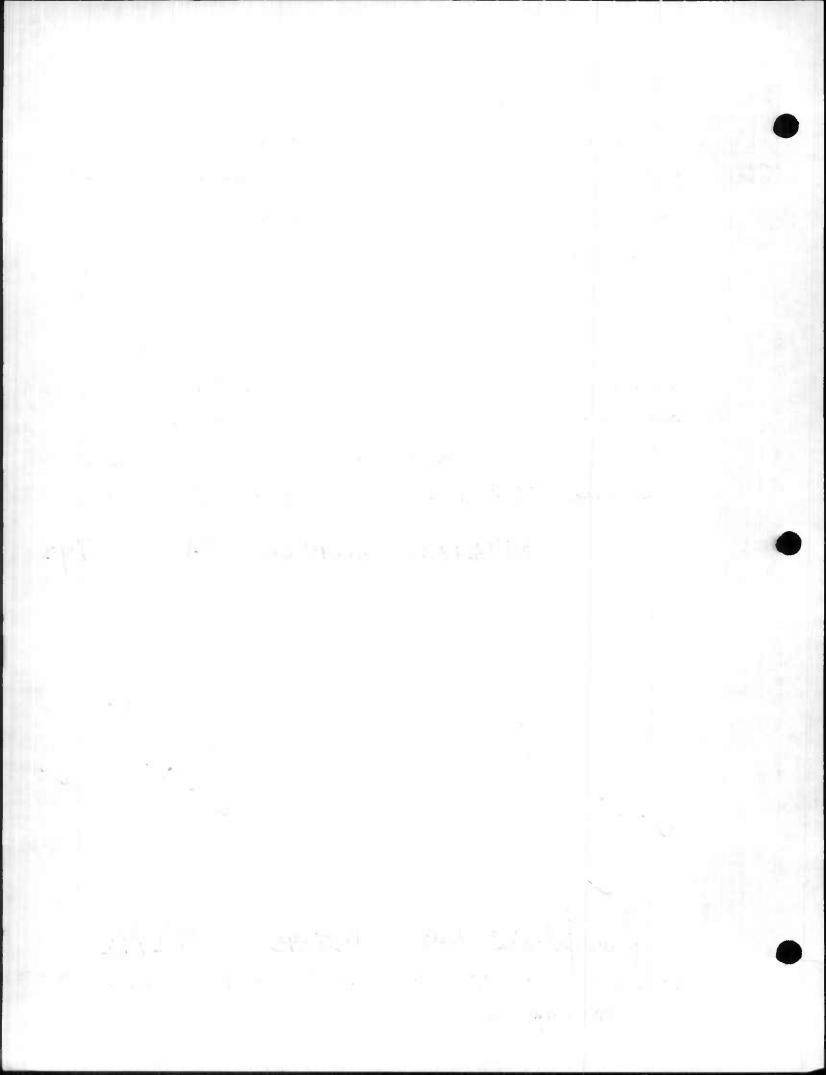
	REGISTRAR		CERT	FIFICATI	E OF	DEATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Lest Shirley WARRE		Hes	ss			2. DATE OF DEATH AUGUST 25	7, 19	3. TIME OF DEATH 8:12 A.M. M
	4. SOCIAL SECURITY NUMBER 219-01-8142	5. SEX	6. AGE (In yrs. lest birth	RS. IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MAY 22,19	21	8. BIRTNPLACE (State or Foreign Country) BROADWAY, VA
TOR	9a. FACILITY NAME (If not institution, give FREDERICK MEMOR		TAL		REDE	RICK	ATN		INTY OF DEATH EDERICK
DIRECTOR	10a. STATE 10b. COUN	DER I CK	7.1	EMMITS		TION			10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	100. STREET AND NUMBER 9101 WAYNESBORG	PIKE				21727			. S. A.
BY FUR	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARMED YES 2 NO AR OR DATES		If yes, sp		IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	or No-	14. RACE — American Indian, Black, White, atc. Specify: WHITE
ETED.	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)		(Give kin	NT'S USUAL O ad of work done IOT use retired.)	during mo	ON est of working	16b. KIND OF BUS	SINESS/IN	
COMPLET	8 17. FATHER'S NAME (First, Middle, Last)		CARPI	ENTER			CONST		ION
BE CC	WILLIAM HESS					REBE			
5	19a. INFORMANT'S NAME (Type/Print) JULIA M. HESS						Route Number, City or Tow		
	20a. METNOD OF DISPOSITION 1 VI Burlal 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	20b. PLACE AND D	ATE OF DISPOS	SITION (Na	ame of		CATION -	- City or Town, State
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE Skil	1			L GARDEN	CHITY		ERAL HOME
Н	your "	277							, MD. 21727
	23. PAY L Enter the diseases, or shock, or heart fellure IMMEDIATE CAUSE (Finsi disease or condition	. List only one cau	se on each line.				C ANBUIC		Interval Between
	resulting in death)	OUE TO	(OR AS A CONSEQUEN	CE OF):	1/ 10	C MOIST	- MVBUIL	437	1 6 ms
LION	Sequentially list conditions, if any, leading to immediate	b. SEVE	OR AS A CONSEQUEN	CE OF):	C5	TENOS	515 < 1	Cu	12 YEARS?
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSEQUEN	CE OF):	4120	FAIL	MUS E	EF.	20% ZM
CERT	resulting in death) LAST		ARO I A						Z+M
EDICAL	PART II. Other significent condition CONDITIONS		death but not result						AMILABLE PRIOR TO
MEDI	PERLIOPERA	THE MO	riming	'sus	5174	WHALL	1 YES 2	XNO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
	TOBATCO US 25. WAS CASE REFERRED TO MEDICAL	E DID	CONTRI	3 WIE		DEATH.	t.		
PHYSICIAN:	EXAMINER?	HOSPITAL:	ER/Outpetlent 3 🗆 D	OA 4 Nu	R:	e 5 🗆 Residence			
ВУ РН	27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF (Month, D	INJURY 28b ay, Your)	. TIME OF INJURY M		URY AT ORK? YES 2 NO	28d. DESCRIBE NOW I	NJURY O	CCURED
ETED B	3 Suicide S Could not be 4 Nomicide datarmined	26e. PLACE O building,	F INJURY — At home, for etc. (Specify)	arm, street, fac	tory, offic	•	261. LOCATION (Street a City or Town, State)		or Rural Route Number,
COMPLE							to the cause(a) and mar time, date and place, an		ited. the cause(s) and manner as stated.
TO BE C	296 SIGNATURE AND THE OF CERTIFI	MU	Un	vo		29c. LICENSE NUN D 45 8	92	29d. DA	8/29/95
	10. NAME AND ADDRESS OF PERSON WERE	HO COMPLETED CAUS		Type, Print)	THO	MAS. H	HUSON D	n	FREDERIKK MD
	31. DATE FILED (Month, Day, Year) SEP Q 1 199	32. REGISTRA	R'S SIGNATURE	do	2011	.,			

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2 Date of Death Physician BARBARA LEA HOSSLER SEPT 1998 8:15 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1707 FAIRMOUNT ROAD HAMPSTEAD CARROLL 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 20 F Months Deys Hours 213-38-5884 Yrs. 58 Director AUG 22,1940 MARYLAND Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 1 No MARYLAND CARROLL HAMPSTEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9 1707 FAIRMOUNT RD 21074 USA Items 23a Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter inent of Heelin and Mental Hygiane.
nn: If Item 27 is marked other than "natural", or item
ury or other traumatic event, tra Medical Examina Anned Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 9 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS B. MYERS ERMA R. THERIT 10 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) TERESA ROBERTSON, DAUGHTER P.O. BOX 529, HAMPSTEAD, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 EXCremation 3 ☐ Removal from State permit. Page Dapartment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATIONS 9/9 HAMPSTEAD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ELINE FUNERAL HOME Lac 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** LARYNGEAL /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner physician end s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) esn 0 P.O. ed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Dr6babty 4 Unknown signed t Records, ģ been sig 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of ceuse of deeth? certificate has b 1 UYes 2 No 1 Yes 2 10 Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifice completely filled in by the funeral director; p. Be 25. Was cese referred to medicel 26. Plece of Death (Check only offe) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 30. Name and replated cause of death (Item 23a) (Type, Print) 224 Washinston Haldo, Westminster, MD21157 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 0 8 1998



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5-0020	within 72 hours after death with the Maryland liehe. Then "natural", or items 23s or 25s-f show the Medical Exercises routiles and the death and the modified at the Medical Exercises.	Completed	/Sn	15. Decedent		ed)	1	6e. Dece	dent's Usuei Occi	pation	of working	16b. Kind of E	Business/Indus	stry
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more,	Heart tarm		20a. Method of Di	sposition			20b. Place	e of Dispe	osition (Neme of	local G	Dete	20c. Location	- City or Towr	n, Stete
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				am L. Ki		M-00		13	10 Speer Ro	oad, Ches	tertown, M	aryland 21	.620	
			23a. Part1. Enter shock, or he	the diseese, or eart feilure. List	complications the	et ca on each	the deeth. [Do not en	ter the mode of d	ing, such es c	ardiac or respiretor	y errest,	A	pproximete ntervel Between
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5	er de	ti Ei	3 Suicide	6 Could r	ned 200. F	lece of Injuited	ury - At home c. (Specify)	, ferm, st	reet, fectory, offic	9		on (Street and Num Town, State)	ber or Rural I	Route Number,
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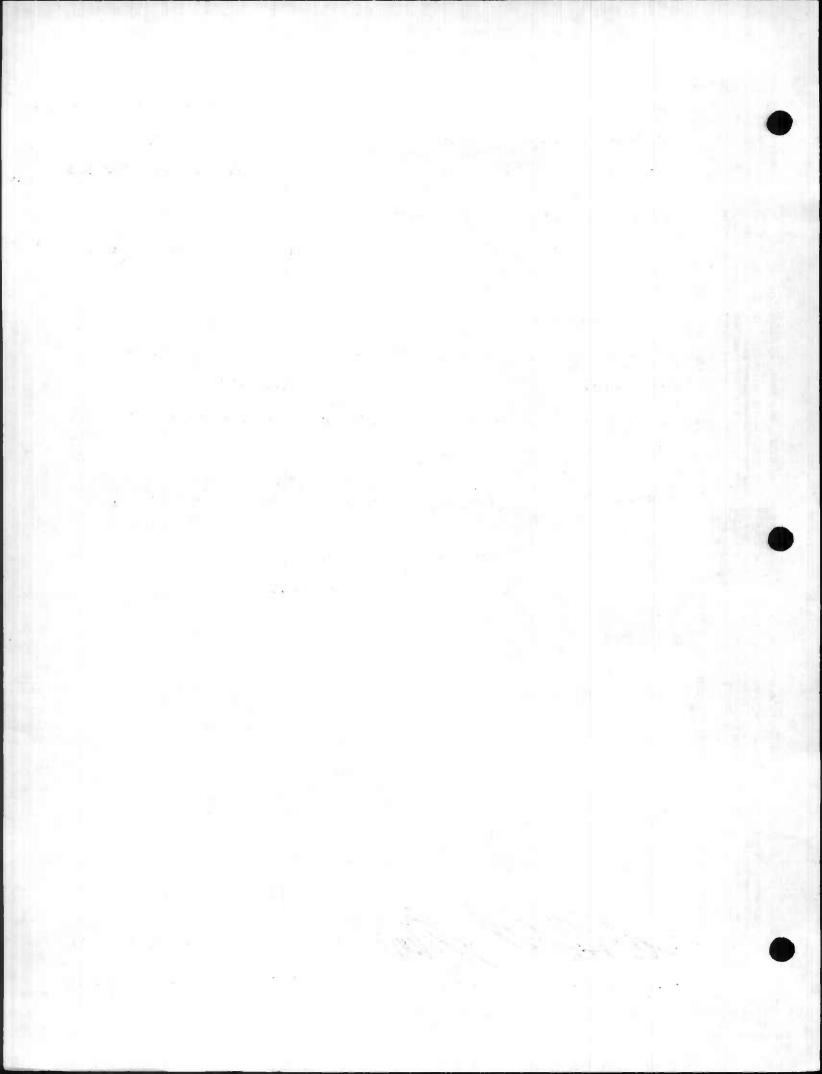
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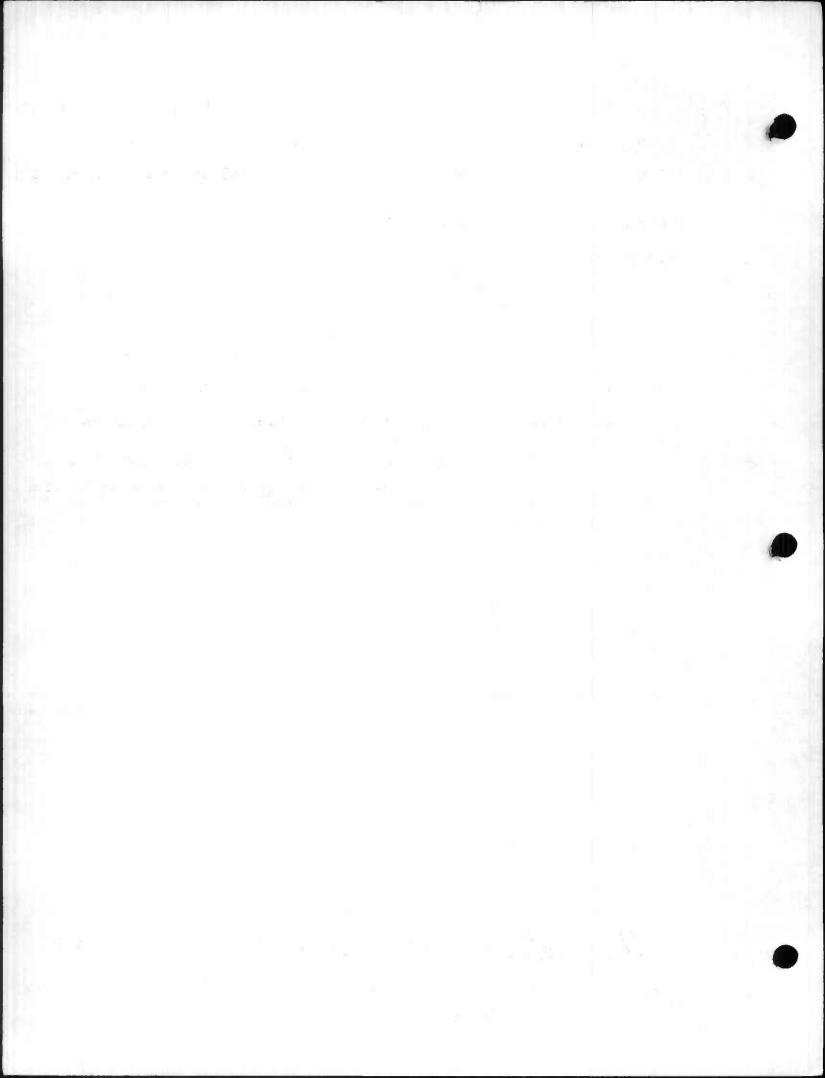
State of Maryland / Department of Health and Mental Hygiene

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Exami		4e Facility Name (If not institution, gi	ve street and number)			4b. City, To		cation of Death	-						
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2 0 8	Medical	that initiated events resulting in death) Last	C	Due to (or as e	conseque	nca of):										
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To the Hospital or Atte within 24 hours after de To the Funeral Directo	edical		nysician: To the best miner: On the basis of and manner.)			
To the	M	29b. Signeture and the of activities	100	1	1.	29c. Licen	se number			29d. Date signe	d (Month,	Day, Year)				
5		Made	8/	10/1/	WID)	D01	120		S	SEPTEMBE	R 4,	1998				
- NES		30. Name and address of person who WALTER E. GOOZH,	M.D 12	99 LAME) (Type, Pro	N DRIVE	- SII	VER	SPRING,	MARYLA	ND 2	0902				
St Regist	ate rar	31. Dete filed (Month, Dey, Year) SFP 0 8 1998		rer's Signeture	9.	Sparks	/									



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Funeral Director		577-07-9840	i. Sax 1 □ M 2 💢 F	Age (In yrs. le:		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, July 28	Year) 1914	9. Birthpled Country Washir	ca (Steta or Foreign ngton, D.				
and		Usuel Residance of Decedent 10a. Stata 10b. County		10c. City,	Town or Local	tion				10d	. inslda City Limits				
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should be nd Mental marked o	10	19e. Informent's Neme/Relationship			19b. Meiling	Address (Street	end Number or Run			Stata, Zip Co	ode)				
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8 5 -		20e. Method of Disposition 1 ☐ Burlel 2 ☐ Cramation 3 4 ☐ Donetlon 5 ☐ Other (Spe		ete can	ca of Dispositi matary, crame c Creek	tory or othar pla	ce) Sept. 8	. 1998	20c. Location - ashingt						
permit. Page Department of Important: If any Injury or once.		A Donetton 5 Other (Specify) Rock Creek Cemetery Washington, D.C. 21. Signature of Funeral Sarvice Licensee Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, M00335 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23e. Pertl. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, interval Betheval Bethev													
/Medical Examiner bubbeigan and a the burial-transit	edical Examiner	immediate Cause (Finel disaasa or condition rasulting in death) Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last	· Chro	Due to (or a			fulm	onarg	, D18	Di rase I	AYS)AYS				
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Hospital or Attending 24 hours after death. Funeral Director: After risk filled in by the fune	Certification:	1 Netural 5 Pending 2 Accidant Investige 3 Suicide 6 Could no	(Month,	Dey Year)	injury	28c. Injur Wo M 1 [rk? Yes 2 No	28d. Describe ho	raat and Numb		Route Number,				
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To the within 2	W	29b. Signature and title of cartifier	Llih	15	10	29c. Licens	orge to w	2 ح	eptem L	Month, De	1998				
27.6		30. Neme end eddress of person with	o completed causa o	of deeth (Item 2	3a) (Type, Pri	int)			Rey	20 d =					

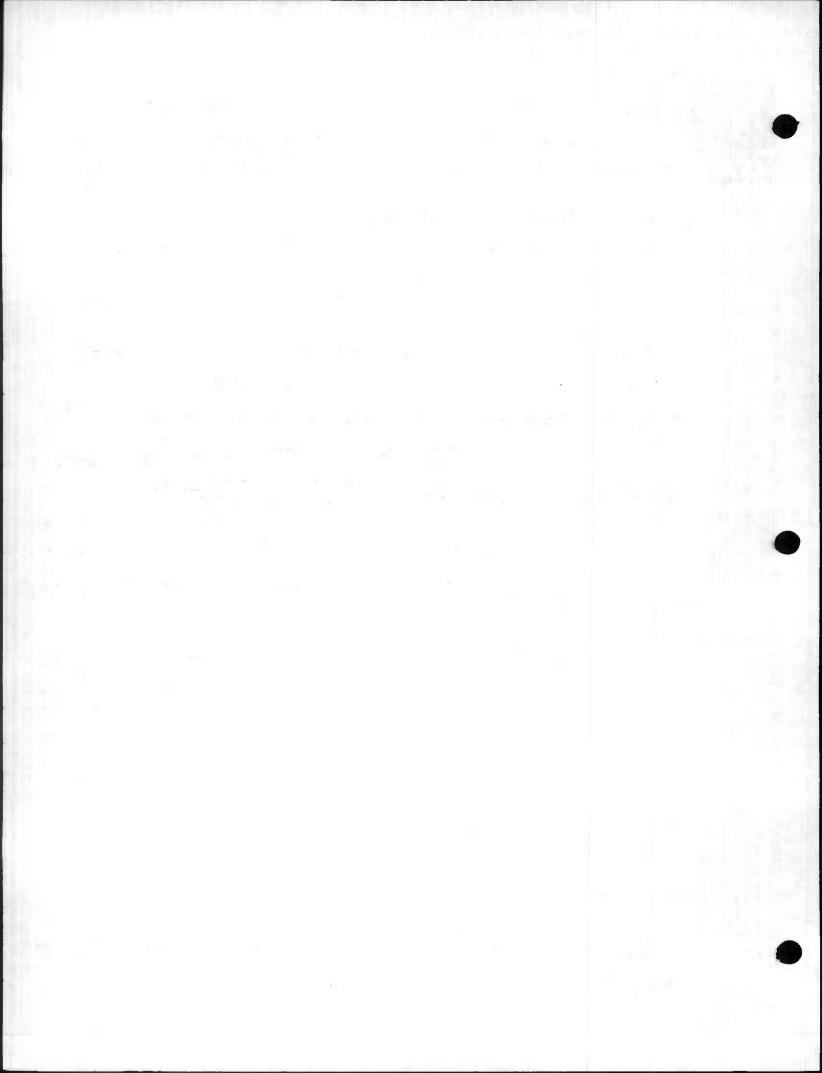


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Data of Daath 3. Time of Death **Physician** Month P. JOHN SON 9, HILDS SEPT. 9:05 AM 1998 /Medical 4a. Facility Nema (If not institution, give street end numbar) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY H Under 1 Year If Undar 24 Hrs. 8. Data of Birth Months Days Hours Min. Feb. 6, 1920 5. Social Security Number 7. Aga (In yrs. lest birthday) 9. Birthplaca (Stete or Foreign **Funeral** 1□ M 21 F Ohio 78 Yrs. 273-18-2255 Director Usual Rasidance of Decedant 10e State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f ahow Examiner must be notified at 10d. Insida City Limits Hamilton Director Yes 2 No OH Cincinnati 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3519 Hudson Avenue 45207 U.S.A. deeth Funerai 12. Was Decedant Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status Was Dacedant of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) should be filed within 72 hours efter on Mental Hygiane.

marked other than "natural", or ite 1 Navar Merriad 2 Marriad 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 Specify: Black 1 Yas 2 No Specify: by 3₺ Widowed 4 Divorced Completed traumatic event, tre Medical 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Tax Examiner U.S. Government permit. Pages 1 and 2 should be file Department of Haalth and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, since. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Willie Payne Rena Smith 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Cod 20904 19a. Informant's Name/Ralationship (Type, Print) 3504 Olive Branch Dr., Silver Spring, MD Terry Vann (Daughter) 20b. Place of Disposition (Nama of Camatary, cramatory or other place)
Thompson=Hall & Funeral Home 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from State Jordan 4 ☐ Donation 5 ☐ Other (Specify) 9/10/98 Cincinnati, OH 21. Signature of Funarai Sarvice Lightness 22. Nama and Address of Facility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 ter the duesas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart future. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** Pulmare Failure /Medical Immediata Causa (Final disaasa or condition rasulting in daath) sirdden Examiner Dua to (or as a consaquance of): Metastahe Carunoma of The Breast Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Dua to (or as a consequence of) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last of Vital Records, P.O. Box 68760, physicien s the burial LUNG + LIVES Dua to (or as a consequence of): neumothorax e175 105 In Know 1 signed by the et Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? page 2 cartificata 1 Yas 2 No 1 Yas 2 No director. 25. Was casa rafarred to madical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) Certification: To this filled in by the funeral 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascriba how Injury occurred 28c. Injury at Work? After Division 5 Panding invastigation 1 3 Natural To the Hospital or Attendir within 24 hours efter deeth. To the Funeral Director: A 1 Yas 2 No 2 Accidant 3 Sulcida 6 Could not be detarmined 28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the bast of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated.

2 Medical Examinar: On tha basis of axaminetion and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated. 29a. Certifier Medical 29b. Signatura and titla of cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 206959 auce Seblember 9, 1998 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Elba Martinez, M.D. Poton HUDDEN LANE -20854 744 31. Data filed (Month, Day, Year) 32. Pegistrar's Signatura State SEP 1 1 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene ?

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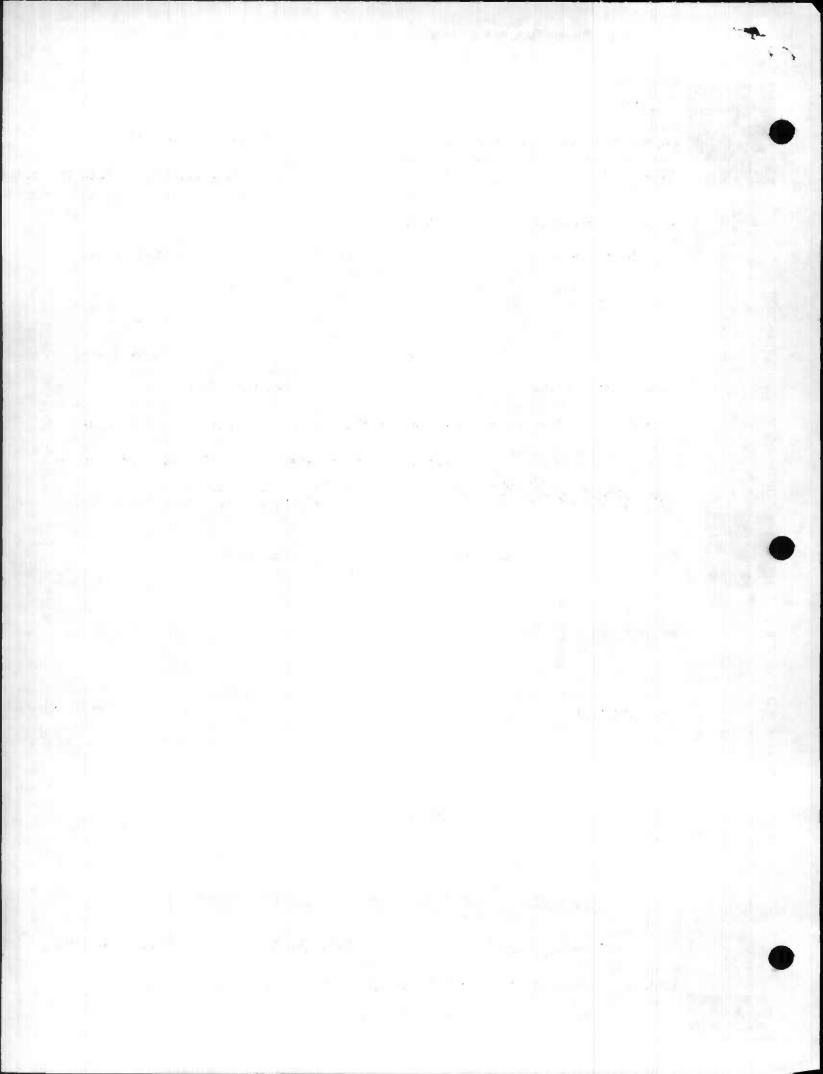
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Funeral Director	5. Social Security Nu 577-72-62 Usuel Residence of E	290	x 7. M 2□F	Age (In yrs. 47	last birthday) Yrs.	If Under 1 Ye Months Day		8. Date of Birt (Month, Da) Jan. 2	y, Year) 3,1951		(State or Foreign gton, D. C			
/land		10b. County		10c. Cit	y, Town or Lo	cation				10d. In	side City Limits			
72 hours after death with the Maryland netural; or items 23s or 28s-f ahow deat Examinet must be notified at eted by Funeral Director	Maryland	Montgome	ery	Si	lver S	pring				12	Yes 2 No			
or 28	10e. Street and Num	ber				10f. Zip Cod			10g. Citizen of	Whet Country?				
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al; or items 23a or 28a-f show Examiner must be notified at by Funeral Director	11. Maritel Status 1 Never Marrie 3 Widowed 4		12. Was Decede Armed Force 1 Yes 24 If Yes, Give Year or Date	s? No		Was Decedent of the Yes, specify C	of Hispanic Origin? (Souben, Mexican, Puert No Specify:	pecify Yes or No o Rican, etc.)	Specif	ce - American Indick, White, etc. (y): Blac!				
nd Mental Hygiene. marked other than "natural; imatic event, the Medical East To Be Completed by	/Snacit	15. Decedent's Edi	ucation		16a. Dece	dent's Usual Oc	cupation	kina	16b. Kind of B	lusiness/Industry	,			
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permit. Pa Departmen Important any injury 2006	1 Aburiei 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial Cemetery 9/11/98 Suitland, 21. Signature of Function Service Licenses McGuire Funeral Service, Inc.													
	7400 Georgia Ave. N.W., Washington, D.C. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximately a such as a cardiac or respiratory errest, intervel intervel.													
een signed by the ettanding physician end bhould be deteched for use as the bunkl-transit steed by Physician/Medical Examiner	Sequentially list con- if any, leading to imr- cause. Enter Under Couse (Disease or ir that initiated events resulting in death) Le	ditions, nediate ying njury	b	Due to (c	or as a consec or as a consec or as a consec	quence of):								
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or: After the funeration:	27. Manner of Death 1 Natural 2 Accident	5 Pending Investigation 6 Could not be	28a. Date of (Month,		28b. Time o Injury	М	njury at Work? 1 Yes 2 No		how injury occu					
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To the Funeral Director: After this completely filled in by the funeral d Medical Certification: To	and and	Medical Exam	rsician: To the be iner: On the basi and manne	s of examine	owledge, deat etion end/or in	vestigation, in m	e time, date and place ny opinion, death occu	a, and due to the urred at the time,	date end piece	, and due to the	cause(s)			
200	29b. Signature and t	itle of certifier	LM-O				sense number 5 236 DM	-		ed (Month, Dey,				
(b)(1)	30. Neme and addre	ss of person who c	completed cause			Print)				or A la L.				
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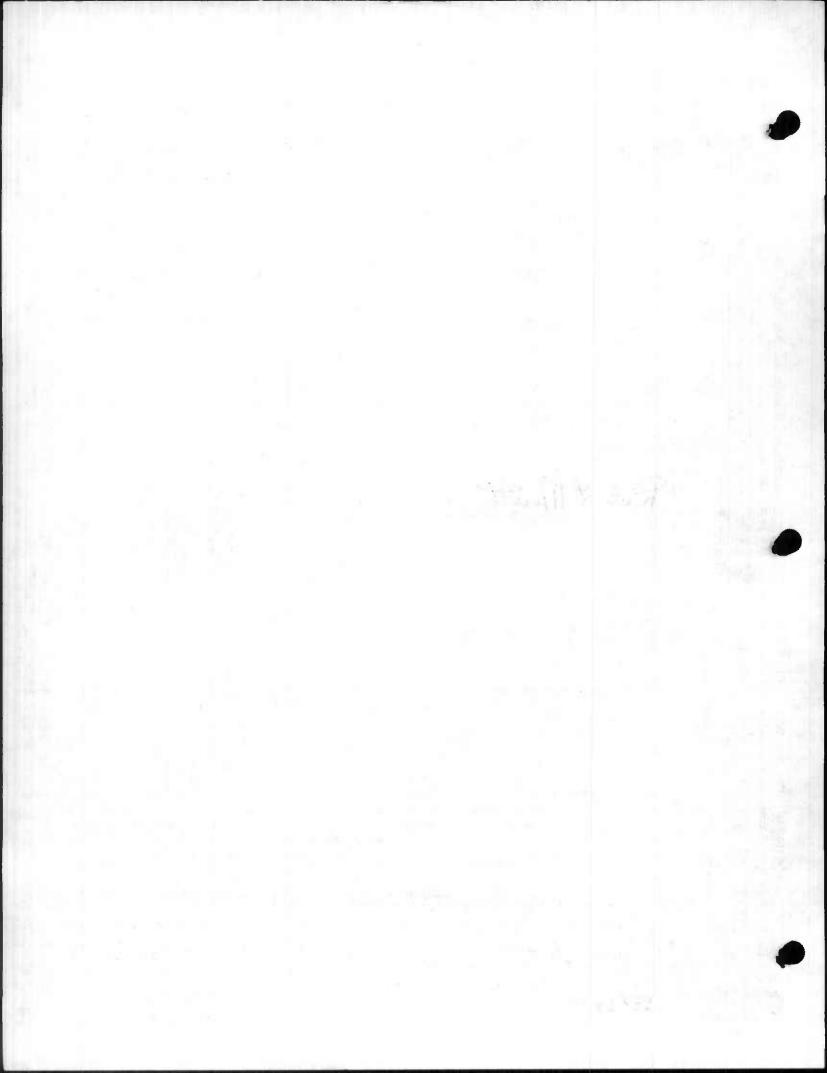


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death Day Physician MARY KATHERINE JEWELL SEPTEMBER 12 1998 9:00 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** 4c. County of Death D.O.A. MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funerai Birthplace (State or Foreign Country) Min 1□M 27 F Months Days Hours 219-14-7191 73 Yrs. Director 1925 MARYLAND MAY 18 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☒ No BEDFORD BEDFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with Herns 23a or RFD#3 BOX#202-C 15522 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Raca - American Indian. Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorcad Year or Dates: 'netural', Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSE KEEPER HOUSE KEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 end 2 should be inent of Health end Mental int: if Item 27 is marked or BERNARD W. O'DONNELL BERNADETTE VIRGINIA THUSS 2 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 end 2 sh Department of Health end Important: if item 27 is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENNETH G. JEWELL RFD#3 BOX#202-C BEDFORD, PA. HUSBAND 15522 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 In Cremetion 3 ☐ Removel from State CUMBERLAND CREMATORY SEPT 13 1998 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME $\frac{404\ DECATUR\ STREET\ CUMBERLAND\ MARYLAND\ enter the mode of dying, such as cardiac or respiretory errest,}$ 23a. Part . Entar the diseasa, or complications that caused the death. Do not enshock, or heart failure. List only one cause on aach lina. Approximate interval Between Onsat and Death Physician tmmediata Cause (Final disease or condition rasulting in death) /Medical a CARDIAC ARRTHEMIA 2 HOURS Examiner Due to (or as a consequence of): Examiner b. A.S.H.D Attending Physician: The law requires that the death certificate be executed physicien end s the buriel-transit UNKNOWN MONTHS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in death) Last Due to (or es a consequenca of): P.O. Box 68760, Physician/Medical Due to (or as e consequence of): use for signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1X Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were sutopsy findings available prior to Completed 24a. Was an autopsy complation of cause of daath? page 2 s certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital director, 25. Was case refarred to medical examiner? Be 26. Place of Daath (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Division of this funeral 27. Manner of Deeth Data of Injury (Month, Day Year) Certification: 28b. Time of 28c. injury at Work? 28d. Describe how Injury occurred After 1 Natural 5 Pending Investigation Injury s after death.

I Director: Al 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours To the Funeral Hospital 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the causa(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. Medical compietely (Check only one) 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) D 09159 SEPTEMBER 12 1998 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) nos DR PAUL SNOW 124 WEST 3rd STREET CUMBERLAND MARYLAND 21502 34 Registrar's Signature

State Registrar



MARK KAPINOS ${
m ASP}_{
m ITEMS}$: #23 PART I, 27 PER MEO G763 9-24-98 WR.

State of Maryland / Department of Health and Mental Hygiene

te of Death	Reg. No:
	2. Dete of Deeth

	Physician
	/Medical
	Examiner
414	LAdiiiiici

Funeral

6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Aga (In yrs. last birthday) Months Days Hours Min. 212-70-7617 Yrs 42 Director Usual Residance of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location r 28a-f show Shrewsbury PA York Directo 10e. Street end Number 10f. Zip Code Hygiene. other than "natural", or flems 23a or ' vent, the Moural Examiner must be 114 Skyview Dr. 17361 Pagas 1 and 2 should be filed within 72 hours aftar death nant of Health and Mental Hygiene.
nt: if Item 27 is marked other than "natural", or Items 23 Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Dates: 1 Never Marriad 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) Collega (1-4or 5+) Design Engineer 7 is marked other traumatic event, i 17. Fether's Neme (First, Middle, Last) Be Stanley Kapinos, Sr. 19e. tntorment's Neme/Reletionship (Type, Print) Lisa A. Kapinos/Wife Item 27 20e. Method of Disposition 1 ☐ Burlal 2 X Cramation 3 ☐ Ramovel trom Stete permit. Paga Department o important: If any Injury or = 6 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Nama and Addrass of Facility 23a. Part1. Part 1. Enter the disaesa, or complete shock, or heert failure. List only of the **Physician** tmmediete Ceuse (Final diseese or condition resulting in death) /Medical IDIOPATHIC CARDIOMYPATHY **Examiner** Due to (or es e consequence of): Examiner physician and s the burial-transit requires that the death cartificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, edicai Due to (or es a consequence of) attanding pl Physician/M signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Division of Vital Records, þ Completed i cartificata has b director, page 2 s Tha law Hospital or Attending Physician: 24 hours after death. Funeral Director: After this carifice 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3X DOA Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 1 (X Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 2 4 - Homicide filled 24 hours a 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. Medical To the Hosp within 24 hos To the Fune complataly fi (Check only one) Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature end, jilly of certifier 29c. License number O.C.M.E

Certifica 1. Decedent's Neme (First, Middla, Last) 3. Time of Death Month Mark E. Kapinos SEPTEMBER 15 199B 10:27 A 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Towson GREATER BALTIMORE MEDICAL CTR. BALTIMORE 8. Date of Birth (Month, Dey, Yeer) Birthplece (Stete or Foreign Country) Dec. 5, 1955 Maryland 10d. tnsida City Limits 1 ☐ Yas 2 No 10g. Citizen of What Country? U.S.A. Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Black, White, atc. Specify: White 16b. Kind of Business/Industry Design Company 18. Mother's Neme (First, Middla, Meiden Sumema) Mollie B. Greenberg 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 114 Skyview Dr., Shrewsbury, PA 17361 Yorktowne Caskets, Inc. Sept. 19, Cremation Service 1998 20c. Location - City or Town, Stete York, PA 17404 .J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 Approximeta Interval Between Onset end Deeth d the deeth. Do not entar the mode of dying, such as cardiac or respiratory errest,

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of death?

Yes 2□No 1 Nos 2 No

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year) SEPTEMBER 16,1998

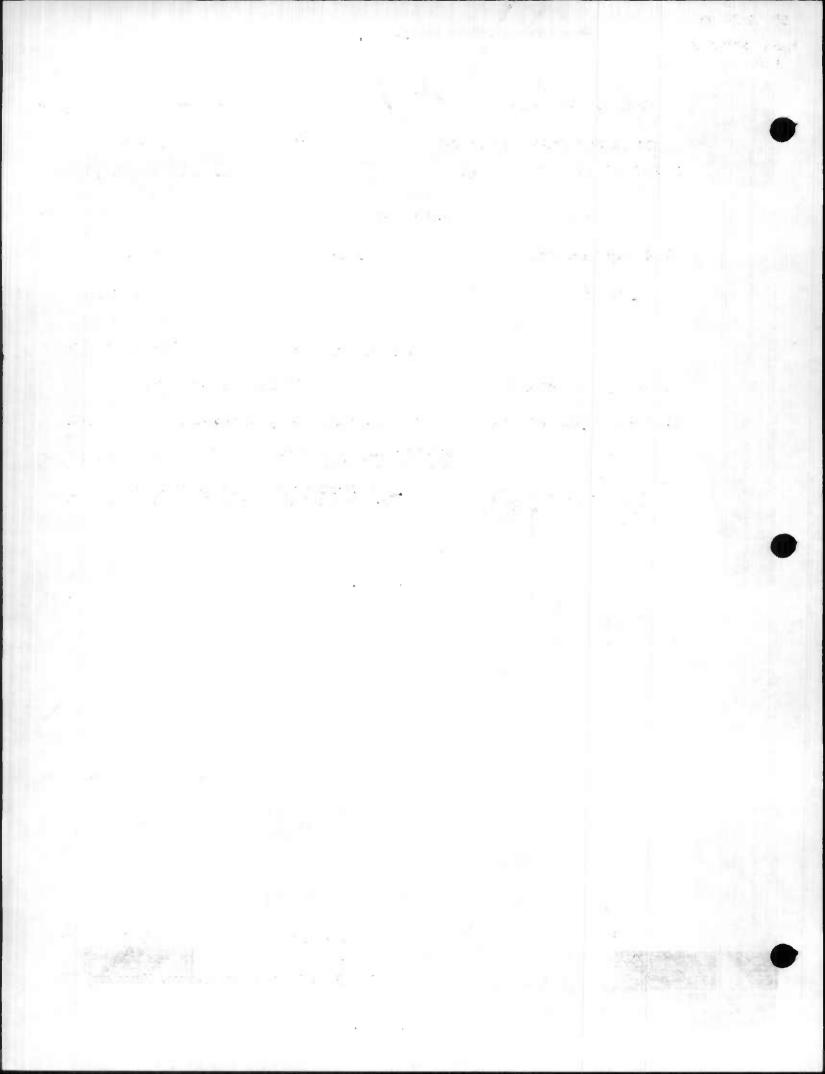
sted cause of death (Item 23a) (Type, Print) ma and eddress of person who come

te m

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Sete of Second 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) **Physician** :10 PY /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Hospital Hunder 1 Yeer COLUMBIA HOWARD Howard County General 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Days 1□ M 25 F Months 86 Feb. 22, 1912 N. 169-26-9435 Carolina Director Usuet Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10h County "natural", or items 23a or 28a-f show XXYes 2 No Director Boyertown Penn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19512 U.S.A. 109 Pine Forge Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours effer of Department of Health end Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or frem page. 1 ☐ Never Merried 2 ☐ Married Specify: Black 1 Yes 2X No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 12th 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Lizzie Collins Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 6185 Prophecy Pl., Columbia, MD 21045 Carol Wallington (Daughter) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Warker-Troutman F/H 9/4/98 Boyertown, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licen 22. Name and Address of Fecility
SNOWDEN FUNERAL HOME, P.A. wa ROCKVILLE, MD 20850 au 23a. Part 1. Enter the riseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or hear milure. List only one-cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by the 20 No 3 □ Probably 4 □ Unknown à 24b. Were eutopsy findings aveileble prior to completion of cause of death? been si Completed 24a. Was en eutopsy page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. Be 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Deeth Tate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier

29c. License number

eted ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Dete signed (Month, Day, Year)

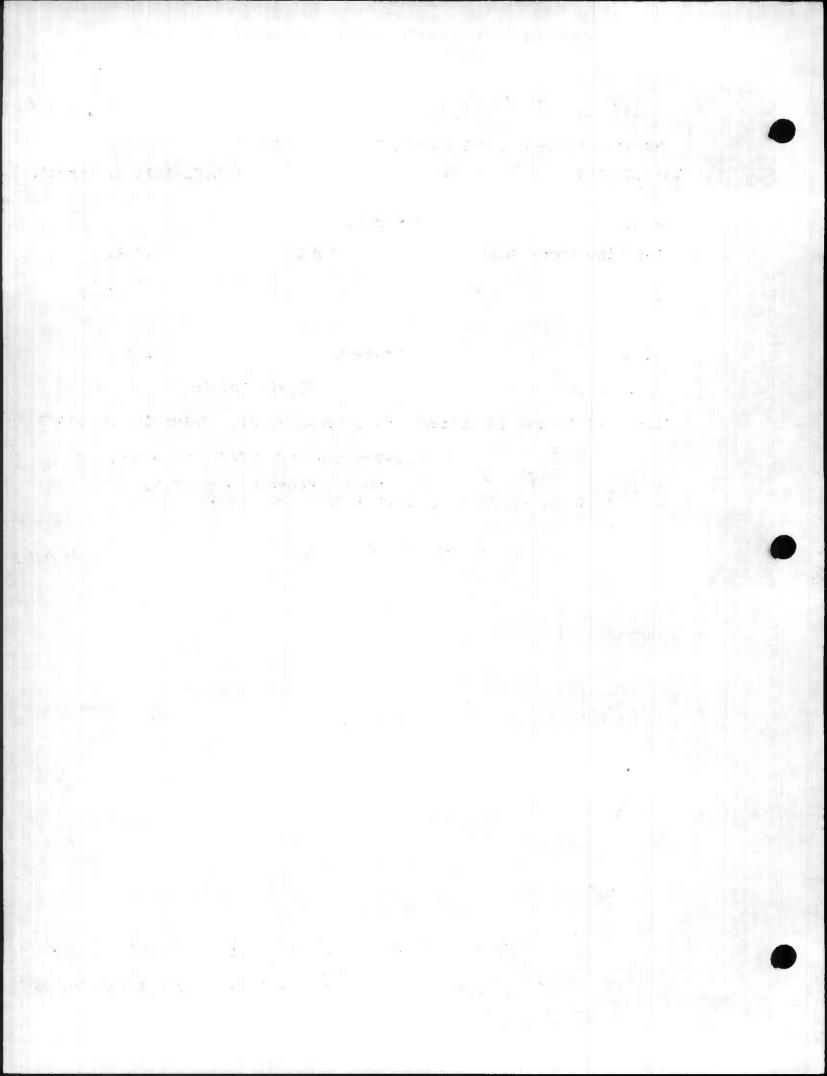
xent Prwy Columbia, mo 21045

State Registrar 29b. Signature and title of coruma

31. Dete filed (Month, Day, Year)

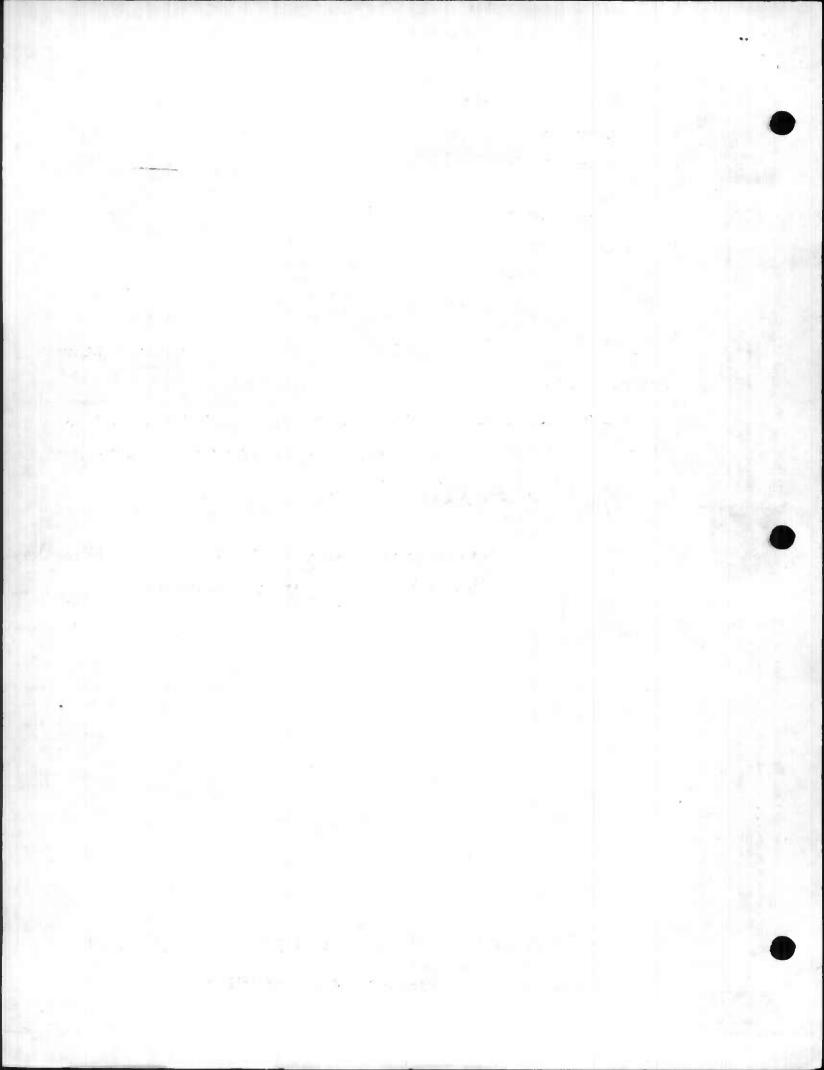
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Brus



Physician /Medical Examiner	1. Decedent's Nam							2. Dale of Dea	Death 3. Time		3. Time of Death	
		ROBERT	А. К	ING				SEPT.	5, Day 199	Xear	9:00 I	
	4a Facility Name (/ 811 Wes			nber)			tb. City, Town, or Rock V	Location of Death		of Death	IERY	
al or	5. Social Security N 217-32-	umber 6.		7. Age (In yrs. 6.2		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year 1936	9. Birthple	ace (State or Fore	
	Usual Residence of			140.00	. Town and an							
ō	MD	Mont.	gomery	Toc. City	y, Town or Loc Rock	ville				10	ld. Inside City Lim 1 Yes 2 ☐ !	
Funeral Director	10e. Street and Nur 811 Wes	nber				10f. Zip Code	20850		10g. Citizen of V	Vhat Count	ny?	
by	11. Marital Status 1 Never Marri 3 Widowed	ed 2 Marned	Armed For 1 ⊠ Yes If Yes, Giv	2 No	1	/as Decedent of H Yes, specify Cub	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Blac	e - America k, White, a	itc.	
Completed	(Special Special Speci				16a, Decede (Give k life. D	ent's Usual Occup kind of work done O NOT use retired	ation during most of wo	orking	16b. Kind of Bu			
Be C	17. Father's Name	First, Middle, La	st)				18. Mother's Na	me (First, Middle,			reore	
TOE	Rober	S. Ki	.ng				Cora	Baker				
	19a. Informant's Na Margare		Rural Route Number									
Department of Health and Mantal Hygi Important: If Itam 27 is marked other eny Injury or other treumetic avent, police. To Be Co		☐ Cremation 3 5 ☐ Other (Spec		State	lace of Disposemetary, creminatory, creminat	ition (Name of latory or other place Park Co	ce) EM .	Data 9/11/9				
ğ	Su	M4 11	· Buo	uko		NOWDEN		L HOME, 20850	P.A.			
by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list confidence is any, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death) is	nditions, imediate thying injury	a	Due to (o	r as a consequence as a	uence of):	lageal	rest Canci	NO Ma			
sicia	Part II. Other signif	icant conditions	contributing to de	ath but not resu	ulting in the un	derlying cause giv	en in Part I.	23b. Did 1	obacco uae co	ntributs to	the cause of dea	
by Physician/Me								10	Yes 2□ No	3 Prob	ably 4 Unkn	
Be Completed b									an autopsy med?	ava	re autopsy finding illable prior to appletion of cause leath?	
Com								101	es 2 No	1 🗆	Yes 2 No	
	25. Was case refer examiner?	red to medical	Hospital:			Ott		eath (Check only o	ne)			
edical Certification: To	1 Yes 2 2 27. Manner of Deat 1 2 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of (Month)	of Injury h, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	4 U Nursing		now injury occur	red	I Route Number,	
cal Cer	29a. Certifier (Check only		Physician: To the	best of my know	wledge, death			e, and dua to tha	cause(s) and ma			
Medical Certification: To Be Comp	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the and mannar stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Da											
	Loo. Organization and	/-	1 Bis	8	MD) 41373		9/9	/190	8	
		/ cm	12000						// /	1 1 1 -1.		

DHMH 16 Flev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth Month 0105 Lottie Mae Keene Facility Nema (If not institution, give street end number) 4c. County of Deeth SPUTESTER GENERIK HOSPITAL AMBRIDGE DRCHESTEN If Under 1 Year | if Under 24 Hrs. 5. Societ Security Number 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) 10 M 20 F Months Deys 79 Yrs. 220-01-9237 Jan. 16, 1919 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland Dorchester Cambridge 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Apt.# 431 701 Race St, 21613 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ∑No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-tf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: **Black** 3 X Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11th Domestic/ Laborer Factory/ Cannery 17. Fethar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Rev. Emmons Foster Mary Thomas 19e. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sarah Foster, Sister 2435 Rock Dr, Cambridge, Maryland 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 N Buriel 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) 9/12/98 Old Field Cemetery Harrisville, Md. 21. Signature of Funeral Service Doensee 22. Name end Address of Fecility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601 or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, List only one cause on each line. Approximete intervei Betw Immediate Ceuse (Final Dew Rours. diseese or condition resulting in death) LARGE THRONDUS IN IVE of RIGHT HEART Soverelled Sequentielly list conditions, if eny, laading to Immediate cause. Enter Underlying Cause (Diseesa or Injury that initiated events resulting in deeth) Lest WITH LARGE COMPLEX on lelvis Due to (or es e consequence of): Plus ie MASS Prosonsing SELGLAL Months. CARC. NOMA Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveltable prior to comptetion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yas 2 ☐ No 25. Wes casa referred to medical axeminer? 26. Place of Death (Check only one) 1 Yes 2 No 1 □ lopatient 2 □ ER/Outpatient 3 □ DOA

The law requires that the death certificate be executed ate hes been signed by the ettending physician page 2 should be detached for use es the buna Records, After this certificate Division of Vital or Attending Physician:

29a. Cartifier

(Check only

Examiner Physician/Medical PV Completed Be 10 Certification: filled in by

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f short next be notified at

items

Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or ite

other traumatic event,

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permit. Page Department of Important: If any injury or

Physician /Medical

Examiner

21215-0020

Maryland

altimore,

Director

þ

Completed

Be

the Maryland

27. Menner of Deeth 1 Natural 2 Accidant 5 Pending investigation 3 Suicide 4 Homicide

6 Could not be datarmined

28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

30. Name end eddress of person who completed cause of deeth (Itam 23e) (Type, Print)

28a. Date of Injury (Month, Day Year)

28b. Tima of

28c. Injury at Work? 1 Yas 2 No

Other: 4 ☐ Nursing Home 5 ☐ Rasidence 8 ☐ Othar (Specify) 28d. Describe how Injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner as stated.

2 Medical Exeminer: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end mannar stated. 29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

State Registrar

Medical

MAHMOOD 31. Date filed (Month, Dey, Year)

SHARIFF 32. Registra 's Signeture

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CAMBRIOGE

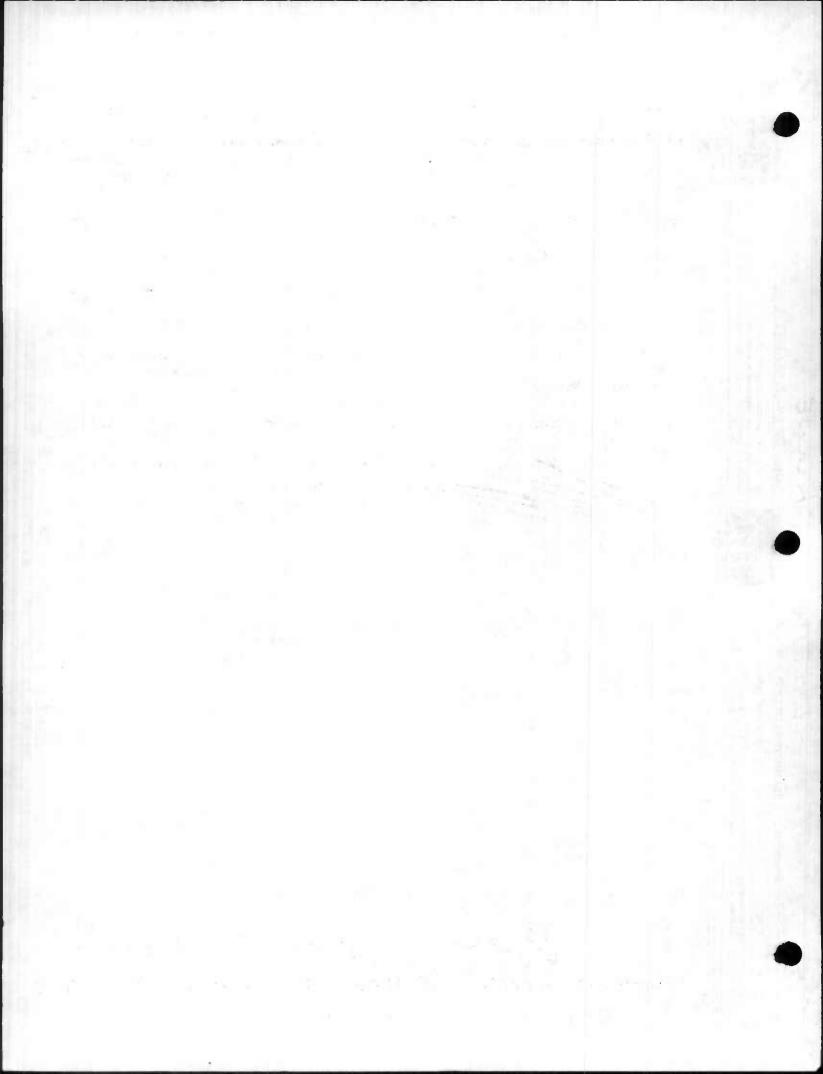
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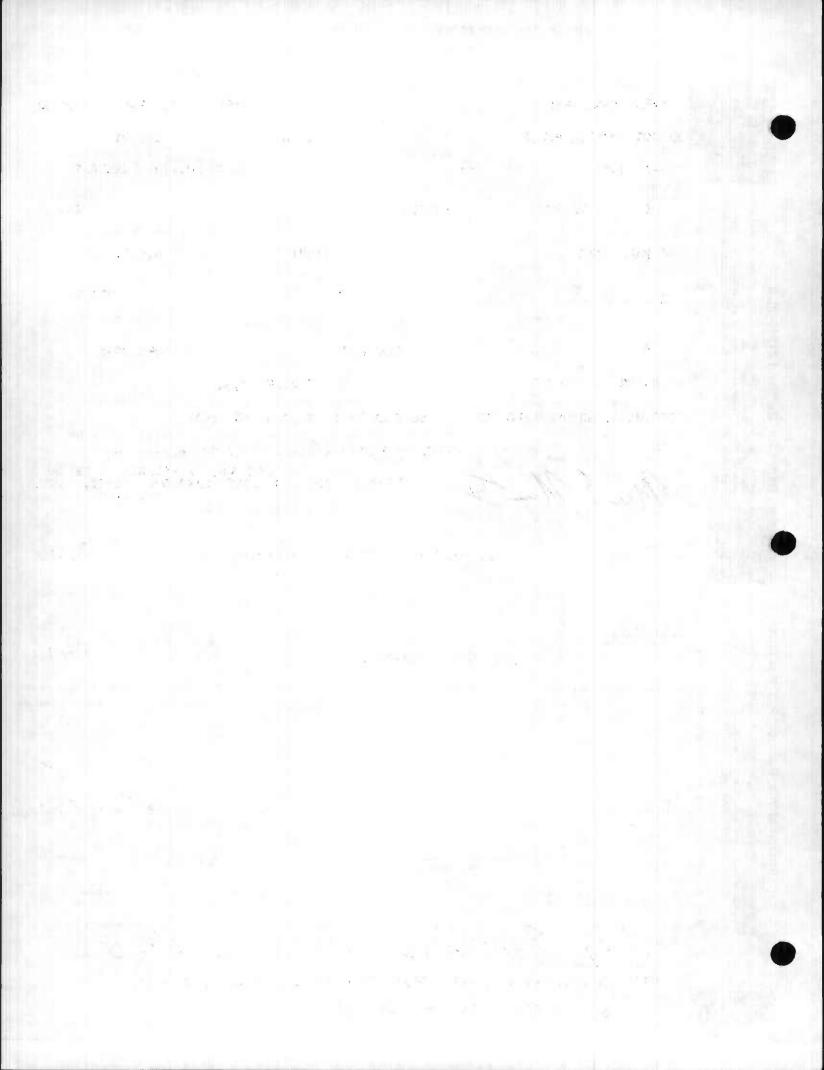
within 24 hours e To the Funeral C completely filled

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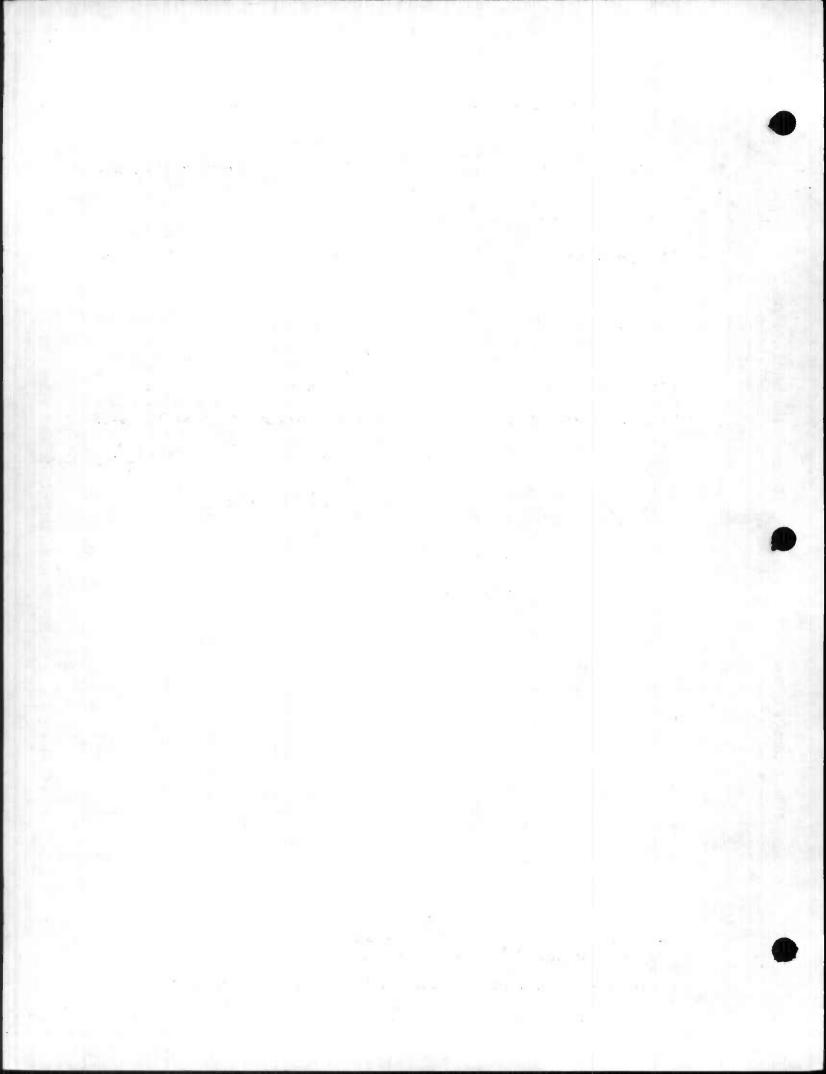


State of Maryland / Department of Health and Mental Hygiene

							(Certifi	icate c	f Death		Reg. No.	5-	3033
Physicia	-	Decedent's Name									2. Date of D Month	Day Day	Year	3. Time of Death
/Medica		LENA	ANNA KA	ASIK					-		SEPT.	8, 19	98	6:00 AM
Examine	_	4a Facility Name (t end nun	nber)				4b. City, Town	, or Location of Dea	th 4c. County	of Death	
81U_L		TALBOT H	OSPICE H	HOUSE						EASTON		TAL		
Funeral Director		5. Social Security N 213-12-3 Usuel Residence of	895	6. Sex 1 ☐ M		7. Age (In yrs 91			Under 1 Ye		Min. MARCH	Sirth Year) 30,1907	9. Birth Cou GERI	place (State or Foreign ntry) MANY
Meryland -f ehow		10a. State MD	10b. County TALI	зот			ity, Town ASTON		on					10d. Inside City Limits 1 1 Yes 2 □ No
h with the	al Director	10e. Street and Nu						1	0f. Zip Cod	21601		10g. Citizen of \U.S		ntry?
0020 ours a	by Fur	11. Maritel Status 1 ☐ Never Mari	ried 2□ Marrie 4 □ Divorced	ed 1	vas Dece rmed For ☐ Yes Yes, Give Year or Da	2色No e	U,S.		Decedent of s, specify C	of Hispanic Origin Juban, Mexican, F	? (Specify Yes or Nuerto Rican, etc.)		e - Ameri ck, White,	can Indien, etc. HITE
5-0 72 ho	e e	/Sne	15. Decedent's				16a. [Decedent's	s Usual Oc	cupation ne during most o	f working	16b. Kind of B	usiness/1r	ndustry
flaryland 2121: 2 should be filed within and Mantel Hygiene. Is marked other than "I cumatic event, in Media	Completed	Elementary/Sec		T	college (1	-4or 5+)		life. DO f	VOT use re IAKER	tired)		OWN	HOMI	E
be filed the filed of other work, in	Be	17. Father's Name		-						18. Mother's	Name (First, Midd	le, Meiden Suman	ne)	
ylan	2	HEINRICK	HOELSO	CHER						HEDWI	G LANG_			
Maryland d 2 should be flie th end Manlel Hy 7 is marked oth treumatic event		19a. Informant's N					19b.	Mailing A	ddress (Str	eet end Number	or Rurel Route Num	ber, City or Town,	Stete, Zi	p Code)
e, Marith e Health e em 27 la rither tre		DOROTHY	A. MURDI	EN/DA	UGHT	ER	86	PARK	LANE	, EASTON	N, MD 216	01		
S 5 5 0		20e. Method of Dis XXBurial 2 4 ☐ Donation	sposition Cremation 5 Other (Spe	3 □Remo	val from S		cemetery	N ME		L PARK,	9-12-98	LIDION	, MD	
Baltimo		21. Signature of F	uneral Service L	m		Til		22. Na FUNE	me end Ad CRAL H	dress of Facility I	SOUTH H	ARRISON	IN, 8 STREI 2160	ET, EASTON,
Physician		23a. Part1. Enter shock, or her	the disease, or cart failure. List o	complicationly one ca	ns thet ca use on ea	aused the dec ach line.	eth. Do no	ot enter th	e mode of	dying, such es ca	rdiac or respiratory	errest,		Approximate Interval Between Onset end Death
/Medical Examiner		Immediate Cause disease or condition resulting in death)		Zyons										
The same of	Jer													
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68760, flicete be axe g physician eas the burial	ca	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											1	
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G for d for	cla	Part II. Other signi	Ificant condition	s contribu	ting to de	ath but not re	sultina In	the under	tving cause	cause given in Pert I. 23b. Did tobacco use contribute to the cau				
cords, P.O. Box requires that the death ceres signed by the attendir hould be deteched for use	by Phys											Yes 2 No		obably 4 Unknown
requiper should	Completed b										24a. We pe	as an autopsy rformed?	6,	Vere autopsy findings vailable prior to ompletion of cause f death?
f Vital Recysician: The law	E										10	Yes 2 No	1	☐ Yes 2 No
Vital	Bec	25. Wes case refe	rred to medical							26 Place o	f Deeth (Check onl			
Of Vita Physician: this certific	To B	examiner?	No	Hospi	tal: 1 🗆 II	npatient 2	□ ER/Outr	netient 3	BDOA	Other	Ing Home 5 ☐ Re		er /Spec	in Hacous V.
Vision of Attending Phys octor: After this by the funeral di		27. Manner of Dea 1 Maturel 2 Accident			a. Date o		28b. Ti	me of jury	28c. I	njury et Work?	28d. Describ	e how Injury occur		11021 Haki
Division or To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the completally filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ot be ned 28	Be. Place buildir	of Injury - At ng, etc. (Spec	home, fari	m, street,	factory, off	ce		(Street and Numi own, State)	ber or Rui	ral Route Number,
To the Hospital within 24 hours or To the Funeral I completely filled	edical	29a. Certifier (Check only one)		xaminer:	On the ba						place, and due to the occurred et the time			
of the of the omple		29b. Signature ago	title of pertifier	1	5	71	1		29c. Lic	ense number		29d. Date signe	d (Month	Day, Year)
F 3 F 0		Vanha (16/1/2000 DZIVI										9/0	191	7
	-	30. Name and address of person who completed cause of death (Item 25a) (Type, Print)												
		LUDWIG	/	SEDER			,			MC TANTE	E A CECAT	MD 2160		
Cana		31. Date filed (Mor		LULK		egistuar's Sign		ADU	LUMMA	NO LANE	EASTON,	MD 2160		
State Registra	-			0 199		Gener	-	9.	ho	askal				



	Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death							3. Time of Death		
Physician /Medical	Constantine E. Lozupone						Septembe:		8:30 P.M	
Examiner	4a Facility Nama (If not institution, give street and number)					4b. City, Town, or I	m, or Location of Death 4c. County of Death			
	9801 Cable Drive					Kensington Montgomery If Under 24 Hrs. 8 Date of Birth 9 Birtholace / State or Foreign				
uneral irector	5. Social Security Number 578-07-8419 Usuel Residence of Decedant			last birthday) Yrs.	If Under 1 Yes Months Day		8. Date of Birt (Month, Day November	16, 1913 I	Birthplace (State or Foreig Country) taly	
show sd.st.	10a. Stata 10b. County 10c. City, Town or Location								10d. Inside City Limits	
or 28e-1 s be notified Director	Maryland Montgomery Kensington				_					
	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?		
must must eral	9801 Cable Dr:	as Decedant Ever in U.S. 13. Was Decedent of H			Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, atc.)		United States 14. Race - American Indian.			
st, or itsma 234 Examinar must by Funeral	1 ☐ Nevar Marriad 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 Yas	Forcas? s 2∭No Siva		f Yes, specify Cu		o Rican, atc.)	Black, Specify:	White, atc. White	
dical	15. Decedar (Specify only highs	nt's Education	on mpleted)		16a. Decedent's Usuel Occupati (Give kind of work done du life. DO NOT use retired)		sation during most of working		ness/Industry	
t, the Medical Completed	Elamantary/Secondary (0-12) Collega (1-4or 5+)			Plasterer				Contracting		
10 m	17. Fathar's Nema (First, Middle,	athar's Nema (First, Middle, Last)				18. Mother's Nan	na (First, Middle,	Maiden Sumame)		
orked affic en	Stephano Lozupone				Maria Colachi			cco		
la ma	19e. Informent's Name/Ralationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Nur 8800 Daimler Court, Potomac,					
item 27 other tr	Carol A. Kenef	ick/Niece				Court, Po	otomac,	-		
in o	20a. Mathod of Disposition 1 ☑ Buriel 2 ☐ Cramation		m Stata '	cemetery, cren	sition (Name of natory or other p	-	, 1998	20c. Location - Ci		
qury qury	4 Donation 5 Other (S		Ga		leaven C				oring, Marylan	
any it	21. Signature of Funeral Service	Licensea	M001	98 Ro	bert A. 7557 Wis Bethesda	Pumphrey Sconsin Av Marylan	Funeral	Home/Bet	hesda-Chevy Chase, Inc.	
sician	23a. Part1. Entar the disaasa, o shock, or haart lailura. List	r complications that t only ona causa or	t caused tha daa n each line.	th. Do not ent	er the mode of d	ying, such as cardiad	or respiratory ar		Approximata intarval Between Onset and Death	
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physician and street st	Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or injury c						isease	-	Indef	
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ed by the attending detached for use a detached for use a Physician/Me	Per II. Other significant conditions contributing to death but not rasult						1	1 Yes 2 No 3 Probably 4 🖔 Unknow		
ate has been signed in page 2 should be det								an autopsy med?	24b. Were autopsy lindings available prior to completion of cause of death?	
page Com								es 2 🖾 No	1 ☐ Yes 2 ☐ No	
rector, par rector, par Be Co	25. Wes case referred to medical axaminer?							ne)		
20 00	1 X Yas 2 □ No	11	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 X Residence 6 Other (Specify)							
Pla Pla										
After th funeral	27. Manner ol Death 1 Natural 2 Accident investi			28a. Placa ol Injury - At homa, larm, street, factory, office building, atc. (Specify)				281. Location (Street and Number or Rural Route Number, City or Town, State)		
octor: After the by the funeral iffication:	1 X Natural 5 ☐ Pandii	nof be 28a, Pla	ca ol Injury - At h ding, atc. (Speci	oma, larm, str fy)	eet, factory, offic		City or Fou	m, State)		
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octor: After the by the funeral iffication:	1 Natural 2 Accidant 3 Suicide 4 Homicide 29a. Cartifiar (Check only area) 1 Certifyir 2 Medical	nof be nined 28a. Pla buil 28a	ding, atc. (Speci	y) wledge, death	n occurred et the vestigation, in my	tima, data end place opinion, death occu	o, end due to the orred at the time,	cause(s) and mann data end plece, an 29d. Data signed (nar as stated. Id due to tha cause(s)	
completely filled in by the funeral completely filled in by the funeral Medical Certification:	1 Natural 2 Accidant 3 Suicide 4 Homicide 29a. Cartifiar (Check only area) 1 Certifyir 2 Medical	nof be and pull and p	ding, afc. (Speci na best of my kno basis of axamine nner stated	byledge, death stion and/or inv m 23a) (Typu	n occurred et the restigation, in my	tima, data end place opinion, death occu nse number D 07099	o, end due to tha c	cause(s) and mann data end plece, an 29d. Data signed (September	nar as stated. Id due to tha cause(s) (Month, Day, Year)	



permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygere. Important: if item 27 is marked other then fratural', or items 23s or 28s-f show any injury or other traumstic event.

Physician /Medical

Examiner

physician and the burial-transit

88 esn

signed by the a

page 2 has

certificate

After this

after deatl

A 24 hound Funeral D

within 24 hou To the Funer completely fil

funeral

filled in by

Hospital or Attending Physician:

To the

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

by

Completed

Be

Certification: To

edical

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Director

Funeral

þ

Completed

Be

		Sta	te of	Maryland	I / Department of Health and M	ental Hygiene 🔾 🤉
F	PER	MEO	G763	9-24-98	WR.Certificate of Death	Reg. No.

	ITEMS: #2	JDWIG 3 PART I, 27, 28A-		63 9 - 24 - 98				
	Physician /Medical	Decedent's Neme (First, Miles)		ise R.	Ludw:	ig		
XI	Examiner	4a Facility Nema (If not institu	No. of the last of	umber)			4	4b. С
	Funeral Director	5. Sociei Security Number 126-14-0036	6. Sex 1 ☐ M 2 🗷 F	7. Age (In yrs. la 75	st birthdey) Yrs.	if Under Months	1 Year Deys	if

3. Tima of Death 2. Dete of Death Month AUGUST 26, 1998 0447AM

29037

City, Town, or Location of Deeth 4c. County of Deeth OCKVILLE MONTGOMERY COUNTY Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (Stata or Foreign Country) New York Nov. 1, Usual Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d, inside City Limits MD Montgomery Chevy Chase 1 Yas 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20815 USA 5610 Wisconsin Avenue 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, Whita, atc. 1 □ Navar Marriad 2 □ Marriad 1 Yes 28 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Nama (First, Middle, Meiden Sumema)

17. Fether's Neme (First, Middle, Last) Rabiner Irwin

Rose Kaplan 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

19e. Informant's Name/Reletionship (Type, Print) Washington, D. C. 44th St. N.W. Kenneth Ludwig -Son 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State 8/30/98 | Falls Church, 4 ☐ Donation 5 ☐ Other (Specify) King David Cemetery

21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Joseph Gawler's Sons 20016 5130 WI Ave. N.W. Washington, D. C.

23a. Pert1. Entar the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line.

Approximata Intervel Between Onset end Deeth

20016

immediete Ceuse (Finel disaesa or condition resulting in death)

a COMPLICATIONS OF SURGERY FOR VENTRAL HERNIA AND LIPOSUCTION

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

Due to (or es e consequence o	of):

Due to (or es e consequence of):

Pert ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i.

8-24-98

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Winknown

24a. Wes en eutopsy

24b. Were autopsy findings available prior to

1 Nos 2 No

completion of cause of death?

Ves 2 No

25. Was case referred to medical exeminer? 1 X Yes 2 No 27. Manner of Deeth

Hospital: 1
☐ Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28e. Dete of Injury (Month, Day Year)

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

HOSPITAL

Injury

UNKNOWN M

28c. Injury et Work?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred COMPLICATIONS OF SURGERY FOR VENTRAL HERNIA AND LIPO-

SUCTION

26. Plece of Death (Check only one)

111 Penn Street, Baltimore, Maryland 21201

28f. Location (Street and Number or Rural Route Number City or Town, State) CHRIDRAN LICENTAL BETHESDA, MARYLAND

29a. Certifier

29b. Signatura and titia of certifiar

1 Netural

2 X Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mennar stated. 29d. Date signed (Month, Dey, Year)

5 Pending

Investigation

6 Could not be determined

29c. License number O.C.M.E.

AUGUST 26, 1998

30. Neme and eddress of person who

Chuteno

completed cause of deeth (item 23e) (Type, Print)

State Registrar 31. Dete filed (Month, Dey, Year) SEP 1 0 1

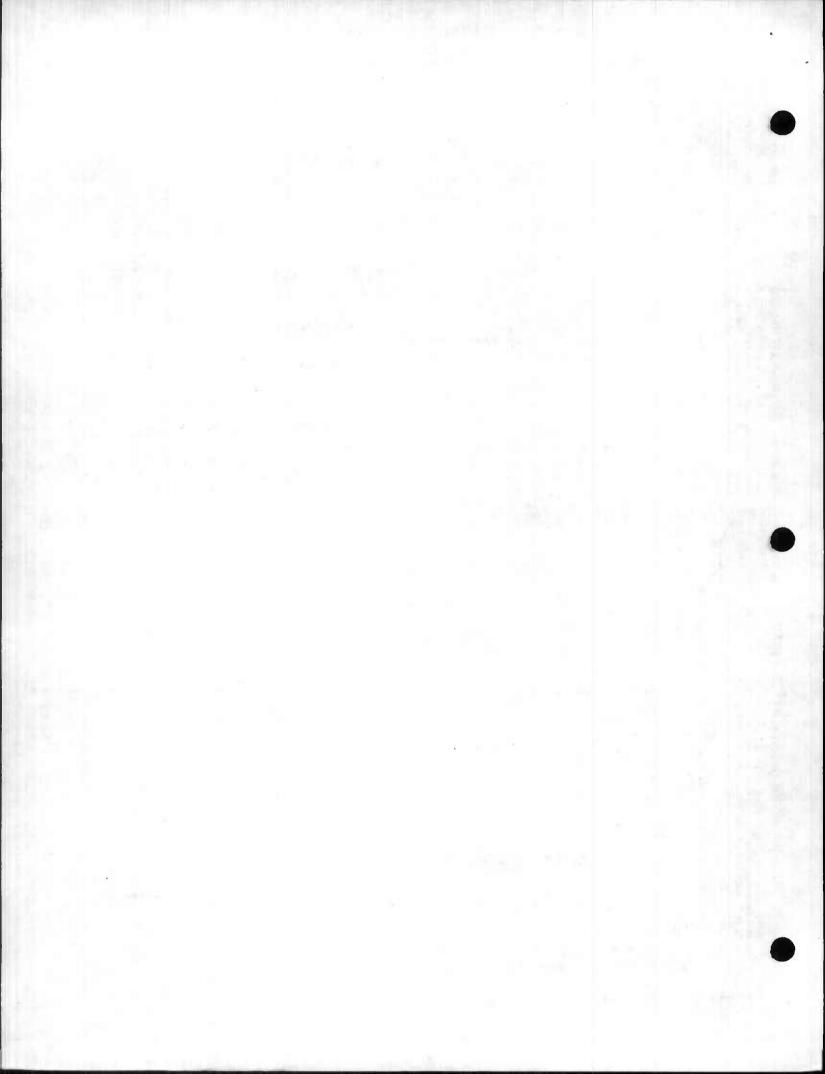
lennisu-

32. Registrer's Signature

Sporks

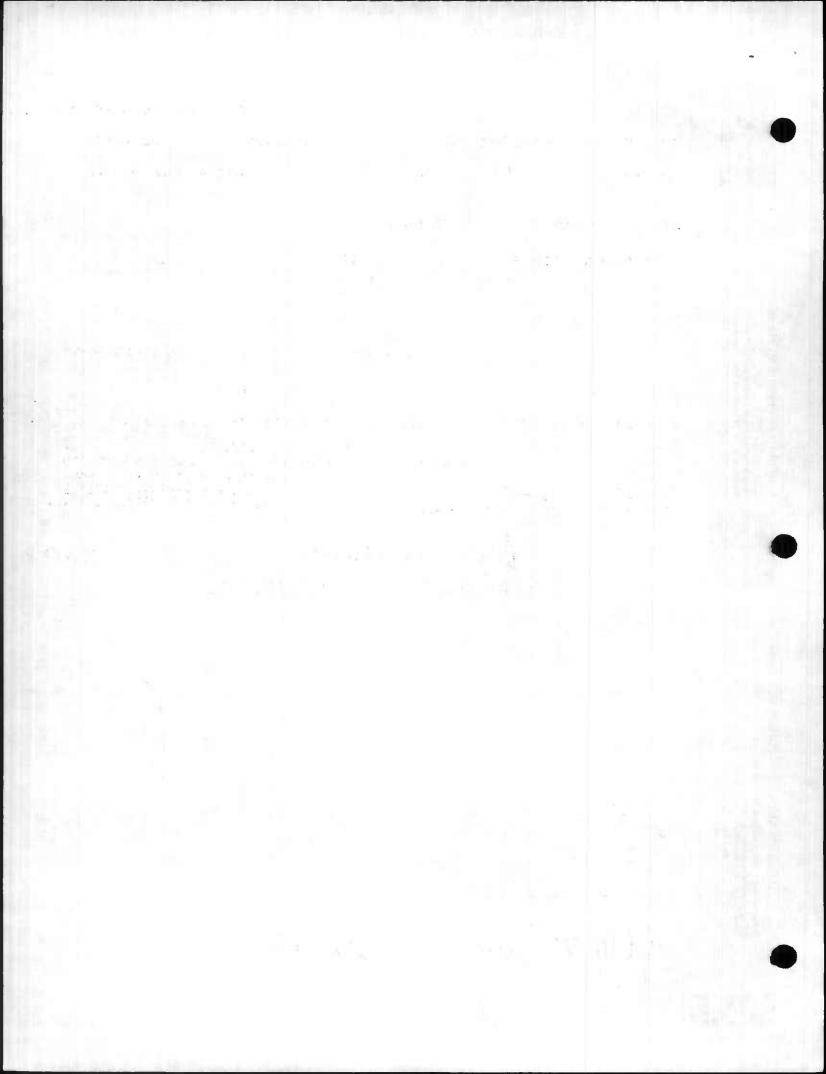
THE STATE OF THE S 11-11 P ACM TELEVISION OF THE RESE

		- P			naryiano / i	-	ficate of	lealth and I Death		Reg. No.	2	9038
	Physician	1. Decedent's Nema							2. Date of De Month	Day	Year	3. Time of Death
5	/Medical			Linehan,				41. O'A. T	_	ber 6, 1		9:50PM .
	Examiner	4e Fecility Neme (#		e street end number Avenue,			(6b. City, Town, or L Silver S				
_		5. Sociel Security N			age (In yrs. lest bi		If Under 1 Yaar	If Under 24 Hrs.	8 Date of Bir	th	ntgom	
E	Funeral Director	048-14-	6381	ØM 2□ F	74		Months Deys	Hours Min.	July II	y, Year) 1924	Conn	lace (State or Foreign try) ecticut
2	ž	Usuel Residence of 10a. State	10b. County		10c. City, Tow	vn or Locat	tion				1	Od. Inside City Limits
Many	to tah	MD	Montgo	merv	Silv	er S	pring					1 ☐ Yes 2 ☒ No
4	28	10e. Street and Nun					10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
in the	r tems 23s or 28s-f single man and the control of t	2209 Wa	shington	Avenue,	Apt. 201		209	10		USA	4	
90		11. Marital Status		12. Was Deceden	t Evar in U,S.	13. We	s Decedent of H	lispanic Origin? (Si an, Mexican, Puerto	pecify Yes or No	- 14. Rac	e - Americ k, White,	
Maryland 21215-0020	Tratural; or items 23s or 28s-1 show odical Examiner must be notified at leted by Funeral Director	1 Never Merrie 3 Widowed	ed 2 Married	1 Yes 2		1	Yes 2 No	Specify:	, , , , , ,	Specify		White
0-0	ted bet	10	15. Decedent's Ed	ducation		Deceden	nt's Usuel Occup	ation	Line	16b. Kind of Bu	siness/Inc	fustry
215	tel Hydione. d other than "natura event, the Medical Be Completed	Elementery/Secon	fy only highest gra ndary (0-12)	College (1-4or	5+)	lifa. DO	NOT use retired	during most of world)	King			
2	of Hyglene. I other than went, the Me			5+		ival :	Physicia				Mili	tary
pu	Be very	17. Father's Neme (18. Mother's Nam			10)	
yla	To To		-	inehan, S					ta Dail	-		
Mai	h and reum	19a. Informent's Na						end Number or Ru				
6	Heelt Pm 27 ther	20e. Method of Disp	P. Lineh	an (20b. Piece C	of Dispositi	ion (Neme of	nue, N.W.	, Wasni	ngton, 1		0015 wn. Stete
Baitimore,	Department regions and a ratious beinged with the population of Heelth and Mentel Hyglene. Important: If Item 27 is marked other than any Injury or other treumatic event, the Mentel Hyglene. To Be Comp	1 🖾 Burial 2 [Cremation 3	Removal from State	a cemete	ry, cremet	tory or other plea		200			
	injury injury	4 Donetion 21. Signature of Fur	5 Other (Specif		Gate o			metery S				
Ba	de la	1	111	1/	h	Hom	e, Inc.	500 Uni	versity	Blvd. V		
		23a Parts Enter th	o disposes, or com	ollications that cause	ed the death. Do		ver Spr:		20901	rrest.	!	Approximete
Р	hysician	aflock, or hear	failure. List-tinly	one cause on each	line.						i	Interval Between Onset and Deeth
	/Medical	Immediate Cause (inal	Rena	1 Cell (larci	noma				1	years
E	xaminer	diseese or condition resulting in death)		е	Due to (or es e					_	- 1	years
_	ě											
.O. Box 68760,	the burlat-transit	Sequentially list cor	ditions,	b. —	Dua to (or es a	conseque	nce of):				i	
0,	ian urlai-	Sequentially list cor if eny, leading to im cause. Enter Under Cause (Disease or	mediate lying niury								1	
8760,	dice the b	Cause (Diseese or that initieted events resulting in death) L	ast	0.	Due to (or es e	conseque	nce of):				1	
X E				d							i	
Box	ed by the attending detached for use at / Physician/Me								1		1	
O E	y the sched	Pert II. Other signifi	cant conditions c	ontributing to death	but not resulting	in the unde	erlying cause giv	en in Part I.				the cause of death?
O. 3	De de	recent p	neumonia	1.20					טי	Yes 2⊠ No	3 Pro	bebly 4 ☐ Unknown
Records,	d de de		1	. 1						an autopsy		ere eutopsy findings ailable prior to
0	should should been si	status p	ost rign	t hip fra	cture				pend	ormed?	CO	mpletion of cause death?
	page 2 should								10	Yes 210 No	10	Yes 2 No
	s certificate he director, page	25. Wes case referr	ed to medical					26. Place of Dec				
of Vital	nis cer Il direc	axaminer?	No	Hospitel:	tient 2 ER/O	utpatient	3 DOA Oth	ner		dence 6 Oth	er (Specif	y)
	ter this neral di	27. Menner of Death	5 Pending	28a. Dete of In		Time of Injury	28c. Injur	y at rk?	28d. Describe	how injury occur	red	
Vision	atte	2 Accident	investigetion	n				Yes 2 □ No				
= >	1 = E	3 Suicide 4 Homicide	6 Could not be determined	Zoe. Piece of I	njury - At home, fo etc. (Specify)	erm, street	t, fectory, office		28f. Location (City or To		er or Rura	al Routa Number,
- 5	Paral Allied	29a. Certifier	12 Certifying Ph	vsician: To the bes	t of my knowledge	e, deeth o	ccurred at the tir	me, date and place	, and due to the	cause(s) end me	enner as s	tated.
H 6	Fur letely	29a. Certifier (Check only one) 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to course deep the tend menner settled.										
Toth	withing thous after the function of the func	29b. Signeture and	itle of certifier	^			29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
	0+1	D23540								Septembe	er 9,	1998
1		30. Neme and eddre	ss of person who	completed cause of	deeth (Item 23a)	(Type, Pri	int)					
	25 52 1	Hugh Hill, M.D., 1450 Research Blvd., Suite 310, Rockville, MD 20850										
	State	31. Dete filed (Mont			trer's Signeture	6	1					
	Registrar	SE	P 1 0 199	18 May	wa	D.	Spark,	2				

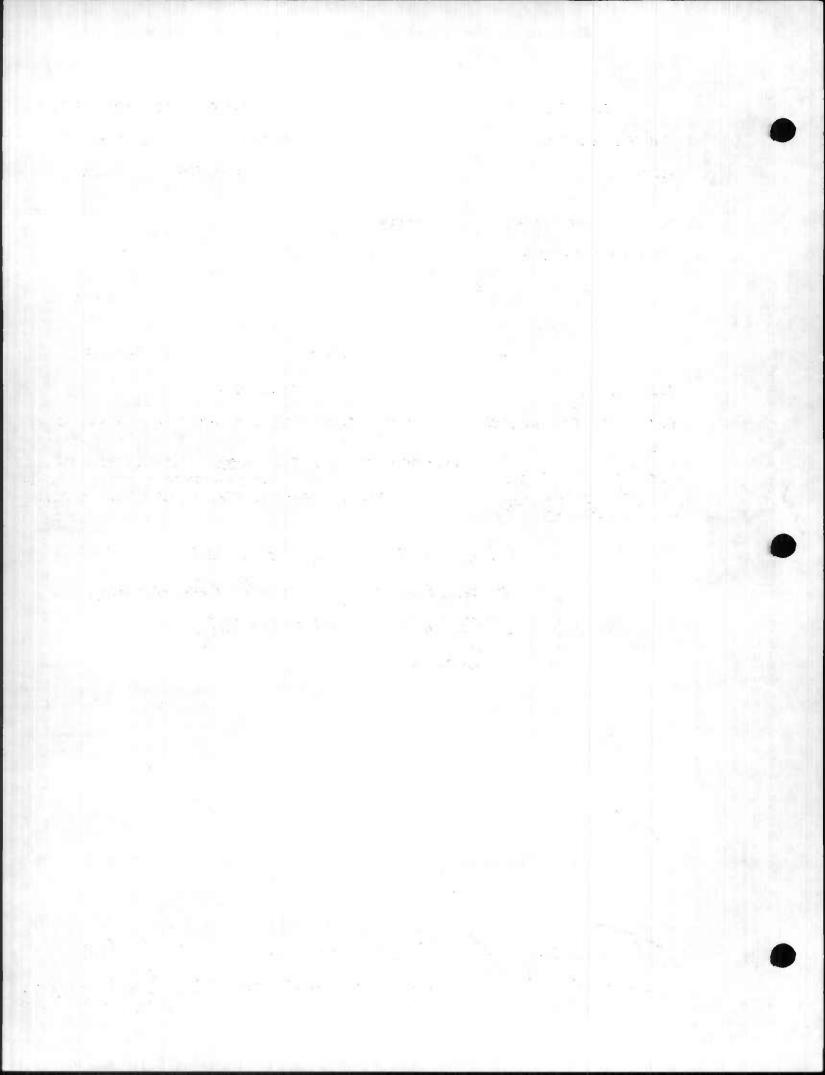


State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death		F	leg. No.) 6	9039
	1. Decedent's Neme (First, Middle,	Last)		4h City Town or				2. Dete of Dee			3. Time of Death
Physician	SONG UI LEE							Month SEPTEMB	FR 3rd	Yeer 199	8 9:40 P.M
/Medical Examiner	4e Fecility Neme (If not institution,	give street end number)			4b. City, To		cation of Deeth	4c. Count		9 7.40 1.1.
Lxammer	20015 SWEETGUM	CIRCLE APT.	#23		G	ERMAN	ITWON		MONTO	OMER	Y
Funoval			ge (In yrs. last birth		r 1 Year	If Under	24 Hrs.	8. Date of Birtl (Month, De)			plece (State or Foreign ntry)
Funeral Director	225-23-8477 Usuel Residence of Decedent	1□ M XX F	58 Yr	Months	Deys	Hours	Min.	JULY 9,	1940	KORE	
Pu Bu	10a. Stete 10b. County		10c. City, Town	or Location						1	10d. Inside City Limits
with the Marylan a or 28s-1 show be notified at Director	MARYLAND MONTGO	MERY	GERMANTO		- 0 - 4 -				10- 011	147	1 □ Yes XXXVo
Dir Den	10e. Street end Number			10f. Zi	p Code				10g. Citizen of	Whet Coul	ntry?
Tal Kan	20015 SWEETGUM			208					U.S.A.		
ther death r Items 23 clost must Funeral	11. Marital Status	12. Wes Decedent Armed Forçes		13. Wes Dece If Yes, spe	dent of Hecity Cuba	lispanic Or an, Mexica	rigin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ ck, White,	can Indien, , etc.
by Exp.	1 ☐ Never Married ※ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	No	1□ Yes	NO	Specify.	:		Specia	y: ASI	AN
다 흔들 성	15. Decedent's	s Education	16e. D	ecedent's Usu	el Occup	ation during mos	st of worki	ina	16b. Kind of B	lusiness/In	dustry
Men T	Eiementery/Secondery (0-12)	College (1-4or	5+)	16e. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)			or work				
w par		4		ASSEMBLY					SOLARI		MPANY
d office of the sevent	17. Fether's Name (First, Middle, L	ast)				18. Moth	er's Neme	e (First, Middle,	Melden Sume	me)	
Menta Menta arked affic e	SHIN IL CHO					IN S	SOOK	PARK			
other	19e. Informent's Neme/Reletionsh	ip (Type, Print)	19b. N	Mailing Addres	s (Street	end Numb	er or Rura	al Route Numbe	r. City or Town	, Stete, Zij	p Code) 20874
27.5	MYUNG SUN LEE (HUSBAND)	200	15 SWEE	TGUM	CIRC	CLE A	PT. #23	GERMAN	NTOWN	MARYLAND
offin offin	20e. Method of Disposition		20b. Place of D	isposition (Ne	me of	cel	10	Date 7	20c. Location	- City or To	own, Stete
y or m	XX Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sp		MEADOWI					EP. 7,	LKRIDGI	T MAP	YI.AND
The state of	21. Signature of Funeral Service L		MEADOWI					ES-RINA			
Dep Amb	1/1-	TH		La. Hamo o	110 110010			00 NEW			
/	July -	The the					SIL	VER SPR	ING MAI		D 20904-289
	shock, or heart feilure. List of	Implications that cause only one couse on each !	d the death. Do no ine.	t enter the mo	de of dyir	ng, euch es	s cardiac o	or respiretory er	rest,		Approximete Intervel Between
Physician		0		. (1						Onset end Deeth
/Medical	Immediate Ceuse (Finel disease or condition	(00)	IVATORY	th	lur	e					4m0>
Examiner	resulting In death)	0	Due to (or es e	nséquenca of):						
		DALLO	ni An	11/1/	(M	MO	ma			
n and ial-transit Examine	Sequentially list conditions	6 1 15 110	Due to (or es e co	nsequence of		CVIIO	(110				
S S S S S S S S S S S S S S S S S S S	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury										
nding physician and use as the burial-trun	Ceuse (Diseese or Injury thef Initieted events	C	Due to (or es e co	neoguence of							
ed the	resulting in death) Lest	P-1/L B11/3-2	Dae 10 (0) 63 6 co	isoquonca oi,							
S 0 2		d									
attend Ifor us									/		
ed by the attend deteched for us	Pert II. Other significant condition	is contributing to death I	out not resulting in t	he underlying	cause giv	en in Pert	I.				to the cause of death?
								101	res 200 No	3 □ Pro	obably 4 🗆 Unknown
5 8 6										1	
should t									en eutopsy med?	9/	Vere eutopsy findings veilebie prior to
S CA CT									/	of	ompletion of cause f deeth?
page 2	- y							101	es 2 No	1	☐Yes 2☐No
certificate rector, par	25. Wes case referred to medical					26. Plea	e of Death	h (Check only o			
direct	exeminer?	Hospitel: 1 ☐ Inpati	ent 2 ER/Outp	atient 3 D	OA Oth	or.		me 5 PResid		her (Sneci	ifv)
E E	27. Magner of Deeth	28e. Dete of Inj	ury 28b. Tir	ne of	28c. Injui			28d. Describe h			.7/
After funer	1 ☑ Naturel 5 ☐ Pending	(Month, De	ey Year) Inj	ury M		rk? Yes 2□					
deat tor: the	3 Suicide 6 □ Could no	ot be one Diseased in	jury - At home, fem			Li -		28f. Location /5	Street end Num	ber or Rur	rel Route Number,
after deat Director: J in by the	4 ☐ Homicide determin		tc. (Specify)	, su ss t, lacto	y, onice			City or Tow		_u. vi i iui	
24 hours a Funeral D stely filled i											
To the Funeral Direction of the Completely filled in Medical Cert		Physician: To the best xaminer: On the basis of	of examinetion end/								
within 24 hours To the Funeral completely filled Medical Co	0 1 1	end manner s									
To to com	29b. Signifiure and yilled of certified	- VT		25	C. Licens	e number)		29d. Date sign	ea (Month,	, Dey, Year)
10	MINIMA	alm	-	1	138	68.	-	5	EPTEMB	ER 4t	h, 1998
	30. Name end eddress of person w										
	ALBERT J. STEREN				R DRI	VE #	436 F	ROCKVILI	E MARY	LAND	20850
State	31. Dete filed (Month, Dey, Year)		rar's Signeture	-							
State Registrar	SEP 0.8		never	9. 1	Day	61					

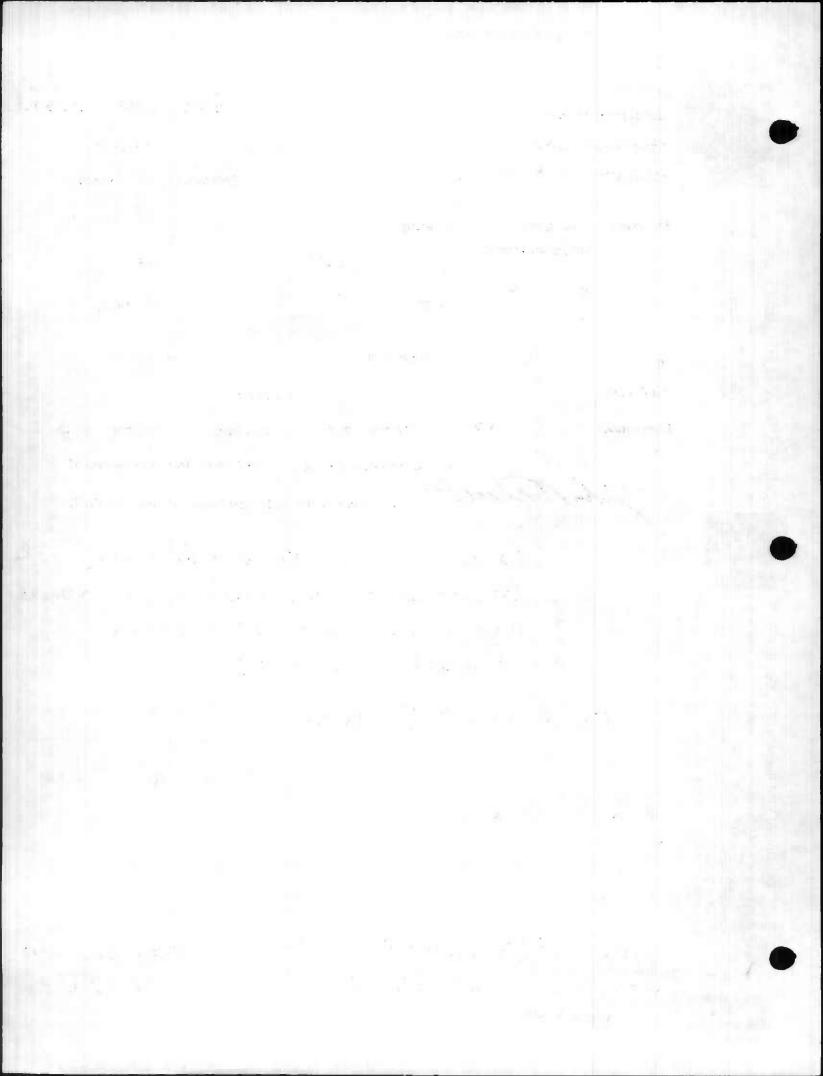


Physician /Medical Examiner	1. Deceder	nt's Name (Fi	irst, Middle,	Last)			1000				2. Date of De	eath Day	V-	ear	3. Tima of Death
	1075	YC	NG CH	ARN LEI	E					S	EPTEME		9, 19		11:25 PM
	4a Facility			giva street and					4b. City, Town	, or Loc	ation of Deat	. 1	County of I		
1101	6710	MONTE	ROSE R	OAD					ROCE	VIL	LE	1	MONTG	OMER	RY
	5. Social S	ecurity Numb	er 6	. Sex	7. Age	e (In yrs. la	ast birthday)	If Under 1 Year		Hrs.	8. Data of Bi (Month, D				ce (State or Foreigy)
	212-	94-110)4	₩ 2□	F	77	7 Yrs.	Months Days	Hours	IVIII).	11/23/	20		KORE	EA.
	Usual Resi	idence of Dec	b. County			10c. City.	. Town or Lo	cation						10	d. Insida City Limi
5	10000			COMPANI		100.01.91									1 ☐ Yes 2 ŒN
Director	MD 10e Street	and Number		GOMERY			ROCK	VILLE 10f. Zip Coda				10a Citiz	10g. Citizen of What Cour		v?
ă	671	CHOM 0		POAD					20852			rog. Oniz		JSA	, .
era	11. Marital		ROSE	12. Was [Decedent E	Ever in U.S	S. 13. V	. Was Decedant of Hispanic Origin? (S If Yas, specify Cuban, Mexican, Puert			ify Yes or N	p- 1	14. Race - /		n Indian,
by Funeral		var Marriad		Armed	d Forces? as 210 N Give or Dates:			If Yas, specify Cuban, Mexican, Pue		Puèrto F	r (Specify Yes of No- ruerto Rican, etc.)		Black, White, at		
			Decedent's		OI Dates.		16a. Decedent's Usual Occ		pation			16b. Kin	nd of Busin		
텶	Flores	(Specify o	nly highest	grada complet			(Give kind of work done lifa. DO NOT use retired		cupation one during most of working stired)		9				
E	Element	ary/Secondar	y (0-12)		ge (1-4or 5- 4	+)					EDUC	CATIC	N		
Be Completed	17. Father	s Name (Firs	t, Middle, La	ist)				TEACH		Name	(First, Middle	, Maiden S	Sumame)		
OB									KYUN	IG Y	OON				
_				p (Type, Print)			19b. Mailin	g Address (Stree				er, City or	r Town, Sta	ate, Zip (Code)
20a	SONT	AEK T.	LEE	M.D. /	SON		11819	HITCHIN	G POST	LAN	E ROCK	VILLI	E MAR	RYLAN	D 20852
	37	od of Disposit				20b. Pla	aca of Dispo	sition (Name of natory or other pic	aca)		Date	20c. Loc	cation - Cit	ty or Tow	m, State
		urial 2 ∐Cr unation 5 □		Removal fr	rom State	GATE		EAVEN CE		10	/12/98	CIIT	TED C	אדממי	IC MD
	immediate disease or resulting in	Cause (Fina	lure. List or	pmplications tr	on each lin	lid	De fa	ar tha moda of dy	ing, such as ca	rdiac or	respiratory a	arrest,			Approximate Interval Between Onsat and Death
/Medical Examiner	Sequentia if any, laac causa. En Cause (Disthat Initiate resulting in	Cause (Fina condition death) lly list condition ding to immate tier Underlyin sease or Injur	Rure. List or	b	mes	Due to just	as a consequence as a c	uanca of):	y C	rdiac or	Ses Cartery	arrest,			Approximate Interval Between Onsat and Death
-	Sequentia if any, laac causa. En Cause (Disthat Initiate resulting in	Cause (Fina condition death) lly list condition ling to imma- ter Underlyin sease or Injurid events death) Last	ons, diata 9	b	me de la	Due to for	as a consequence as a c	uanca of):	y C	rdiac or	Ses Carrier Ca	arrest,	hou	Mar	Onsat and Death
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State of Maryland / Department of Health and Mental Hygiene

Physician /Medical	Decedent's Name	(First Mirtrile I a	ist)			Certificat	e or	Deam		2. Date of Death	g. No.	die .	3. Time of Death		
	Physicia	n										Month AUGUST	Dav	Year 98	10:25 P.M.
8			Julius Hu 4a Facility Name (#	go Lenkey	/ re street and number	-)				4b. City, Town,	or Loc		4c. Count		10.23 1.11
	Examine	er				,									
	Funeval		5. Social Security N	eart Hospit		ge (In yrs. I	ast birti		1 Yeer		Hrs.	8. Dete of Birth (Month, Day,		egany 9. Birthp	place (State or Foreign
	Funeral Director		151-22-51 Usual Residence of	30	NX M 2□ F	88		rs. Months	Days	Hours	Min.	(Month, Day, 24-Nov-0			Jersey
	lend		10a. State	10b. County		10c. City	, Town	or Location						1	0d. Inside City Limits
	Meny	ò	Maryland	Alleg	any	Frost	hurc	,							1 X Yes 2 □ No
	28e	Funeral Director	10e. Street end Nun	nber		11031	DOL	10f. Zij	Code			10	10g. Citizen of Whet Co		ntry?
	3a o			340 Barr	nard Street				2153	22			II C A		
	deett	Der	11. Maritel Status		12. Was Deceden	t Ever in U,				21532- ent of Hispanic Origin? (S ify Cuban, Mexican, Puert		city Yes or No-	U.S.A. 14. Race - Ame		
21215-0020	a 0 5	Dy Fu	1 Never Marrie	ed 2 Married	Armed Forces 1 ▶ Yes 2 □ If Yes, Give Year or Dates:	No	I	1 Yes			uerto r	iican, etc.)	Specia	ick, White, fy: White	
0-10	netural',			15. Decedent's E	ducation	etion 16a Dece		Decedent's Usu	edent's Usual Occupation			_ 1	6b. Kind of E		
215	C 0	Die	(Speci	fy only highest gra	ade completed) Coilege (1-4or				rk done se retire	during most of d)	workin	g			
21	Pages 1 and 2 should be filed within 72 ho nent of Health end Mantal Hygiane. nt: If Item 27 is marked other than "neturing or other traumatic event, I'm Hedical into or other traumatic event, I'm Hedical into or other traumatic event, I'm Belical into or other traumatic events.	E	8	idaly (0-12)	Ooilege (1-40)	34)	Sup	ervisor				1	Wilitary A	senal	
pu			17. Father's Name (First, Middle, Last						18. Mother's	Name	(First, Middle, M	alden Suma	me)	
Maryland			Paul Lenkey							Vilm	a Bo	ors			
lan		Paul Lenkey					Mailing Addres	S (Street				City or Town	, Stete, Zip	Code)	
			Ellen Lenk	ey	Wife		340	Barnard S	reet		Erost	burg	Mary	land	21532-
altimore,			20a. Method of Disp		Removel from State		lace of ameter	Disposition (Ne	me of other pla			Date 2	Oc. Location		
Ē				5 ☐Other (Special			Mich	ael's Parish	Cem	eterv	28-	Aug-98 F	rostburg	. Marv	land
alti	permit. Pag Department Important: It any Injury o		21. Signature of Fu	neral Septce Lice	Isaa	1				ess of Facility					
0	Dep June Per	1	1	fen /	Alu	w		Duret Fu	nera	Home 5	7 Fre	ost Ave., Fr	ostburg	MD	01532
100			23a. Paul. Enter th	e disease, or com	plications that cause one cause on each	ed the death	n. Do n							, (410) 2	Approximete
	Physician		prodx, or near	t failure. List only	one cause on each	iine.								1	Interval Between Onset and Deeth
	/Medical		Immediate Cause (I	Final	Cond	2.00		0)//	1 1	-10	61	. 6. 0.	0.0	10	126
	Examiner		resulting In death)		a. Child	Due to (o	rasac	onsequence of		oran	W.C	ng n	Law	TALMUT	u /c
A.C.		i i			. Card	100	1 00	0 E	. 0	inca.	A /	1. 5			3 mar 12
	outec nd ransi	Examiner	Sequentially list cor	nditions.	b. Dac	Due to (or	resac	onsequenca of)	00	UCM.	ve	uac,)		J JYLVJ(OVA
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68760,	ifficate be executed g physician and as the bunal-transit	edical	that initiated events resulting in death) L	njury	0. 113/1	Due to (or	asac	onsequenca of)	1	120	ULD	un) H. VIII	3.62	
99	E 0 6	-	resulting in death) t	,ast	P	2 4	20	(1	1	000	00				
Box	h cer endir	Physician			d	19	S.L	1 0	11	300	1				
	the att	SICI	Part II. Other signifi	cant conditions	contributing to death	but not resu	ulting In	the underlying	cause gi	ven In Part I.		23b. Did tol	bacco uae c	ontribute t	o the cause of death?
P.0	that the de ad by the detached	2		M.0 1	2 2 2	. 0	(02 (1 🗆 Ye	s abouno	3 Pro	bably 4 Unknown
S,	signed ld be del	2		UNO	ren	ax	1	aux	u'l		_			7	
Records,	The law requires that the death centale has been signed by the attending page 2 should be detached for use	Сощріете										24a. Was ar perform		6/	fere autopsy findings reileble prior to empletion of cause death?
Re	The law ete has I pege 2 s	Ē										1 ☐ Ye	s 2 No		☐ Yes 2☐ No
			25. Wes case refer	ad to modical						OC Place of	Death				
Vital	ysicia is certi directo	o De	exeminer?		Hospital:		ED/0	a	Ot Ot	her.		(Check only one	_	to a Consi	4.1
of	£ 5 %	- 1	1 ☐ Yes 2 2 2 27. Manner of Deeth		1 Inpat		28b. T	ime of	OA 28c. Inju		-	ne 5 🗆 Reside 8d. Describe ho			ry)
no	After fune	0	1 Natural	5 Pending investigation	(Month, D	ey Yeer)		njury M	Wo	ork?]Yes 2 □ No					
Division	Attending ir death. ector: Afte by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide	6 Could not b	e Ope Place of In	niury - At ho	me fai	m, street, facto				Rf. Location (Str	reet end Num	ber or Run	al Route Number,
∑i	or A aftar Direction by		4 Homicide	determined		etc. (Specify		111, 3(1001, 18010	y, 011100			City or Town	State)		
	To the Hospital or Attending R within 24 hours aftar death. To the Funeral Director: After completaly filled in by the funer	5	29a. Certifier		nyalcian: To the besi										
	n 24 n 24 ne Fu	edical	(Check only one)	2 Medical Exa	miner: On the basis and manner s		lion and	Vor Investigation	i, in my	opinion, death	occurre	d at the time, da	ite and place	, and due t	o the cause(s)
	To the comp	ž	29b. Signature and	of cartifier	11			29	c. Licen	se number		28	d. Date sign	ed (Month,	Day, Year)
	,		1000E	In K	1040	1111	11	(4-1)	0-	175	-2	6	AUGUST	121	,1998
1	Mag Q	-	30. Name and addre	ess of person who	completed cause of	death (Item	2311	Type, Print)						, – ,	
	· De		John	Mehai	ma m.	5. 9	02.	Seto 1	710	c Cu	mh	erland	ni	0 2/	502
	State	ę	31. Date filed (Mont			rar's Signa	two .	6.	loon	Kel			1		
	Registra	r		MIG 2 8 1	448			1							



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month Dey **Physician** WILLIAM C. LANDIS SEPTEMBER 10,1998 1915 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) **Examiner** SACRED HEART HOSPITAL ALLEGANY CUMBERLAND 8. Dete of Birth (Month, Day, Year) Jul 10, 15 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 WV 7. Age (In yrs. last birthday) **Funeral** Days Months Hours XDM 2DF Yrs 85 **Director** 214-05-9791 Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Y Yes 2 No Allegany Cumberland Director MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "natural", or items 23s or USA 11401 Bierman Drive SE 21502 Funeral 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces?

**Core Yes 2 No
If Yes, Give
Year or Dates **W II Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Reca - American Indien Bleck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes X☐ No Specify: Baltimore, Maryland 21215-3020 þ X□ Widowed 4 □ Divorcad white Completed Description of Health and Albara States of Health and Albara Hoportant: If Health and Menial Hygiena.

Important: If Health and Menial Hygiena.

Bross. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Tire Company Calendar Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Abraham Scott Landis Mary Ellen (Reed) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 11403 Bierman Drive SE; Cumberland, MD Darlene Spencer-daughter 20a. Method of Disposition

Was Burial 2 □ Cremation 3 □ Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Restlawn Memorial Gardens 09/14 LaVale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licensee 21502 Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ehock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and the burial-transit requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 50 esn 23b. Did tobacco use contribute to the cause of death? ed by the a Part ff, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Were autopsy findings evelleble prior to been sig 24a. Was an autopsy performed? Completed completion of cause of death? certificata has b 1 Yes 20 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to findical examiner? director, Be 26. Placa of Death (Check only one) To Hospital: 1 Yes 2 Pho Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. fnjury at Work? Certification: After 5 Pending Investigation 1 Maturat 1 Yes 2 No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide ò filled in I Hospital hours 24 hours 29a. Certifier 1 🔁 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated. edical completely 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) (Check only one) To the vithin 2 29b. Signature end title of 29d. Dete signed (Month, Dey, Year) 29c. License number SEPTEMBER O 7123 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GARY WAGONER M.D. 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502

DHMH 16 Rev 6/95

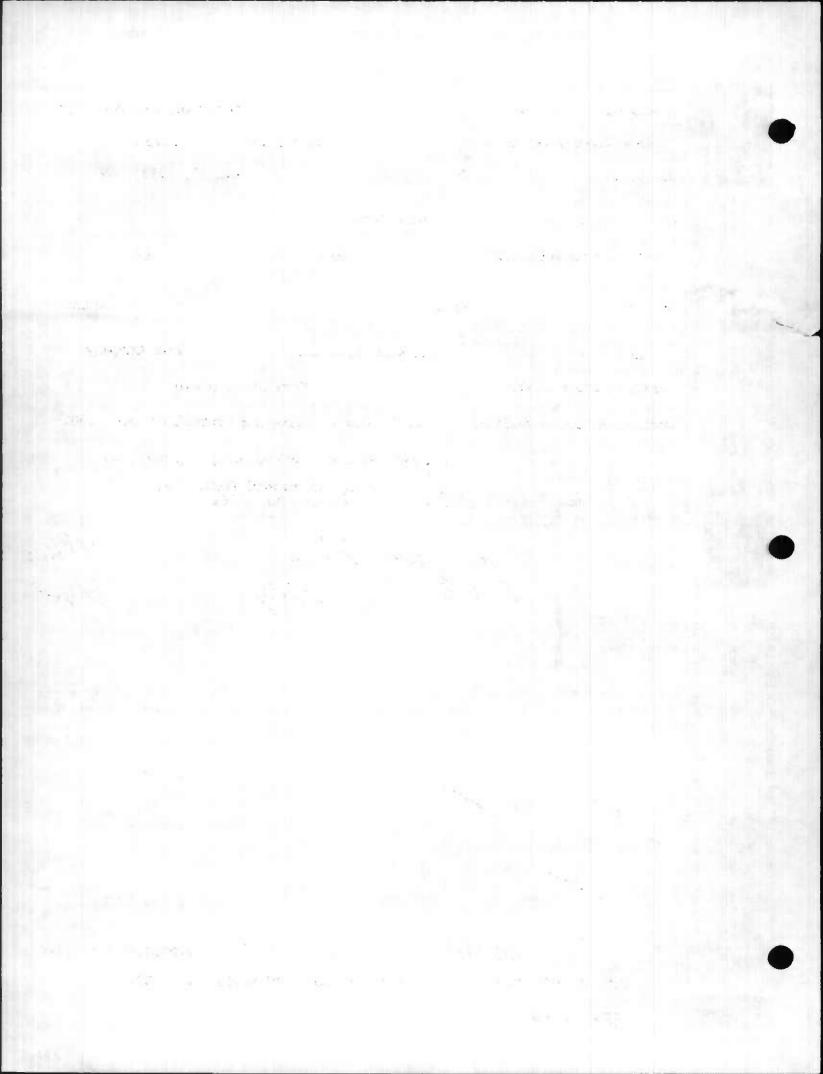
State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 4 1998

32. Registrar's Signature



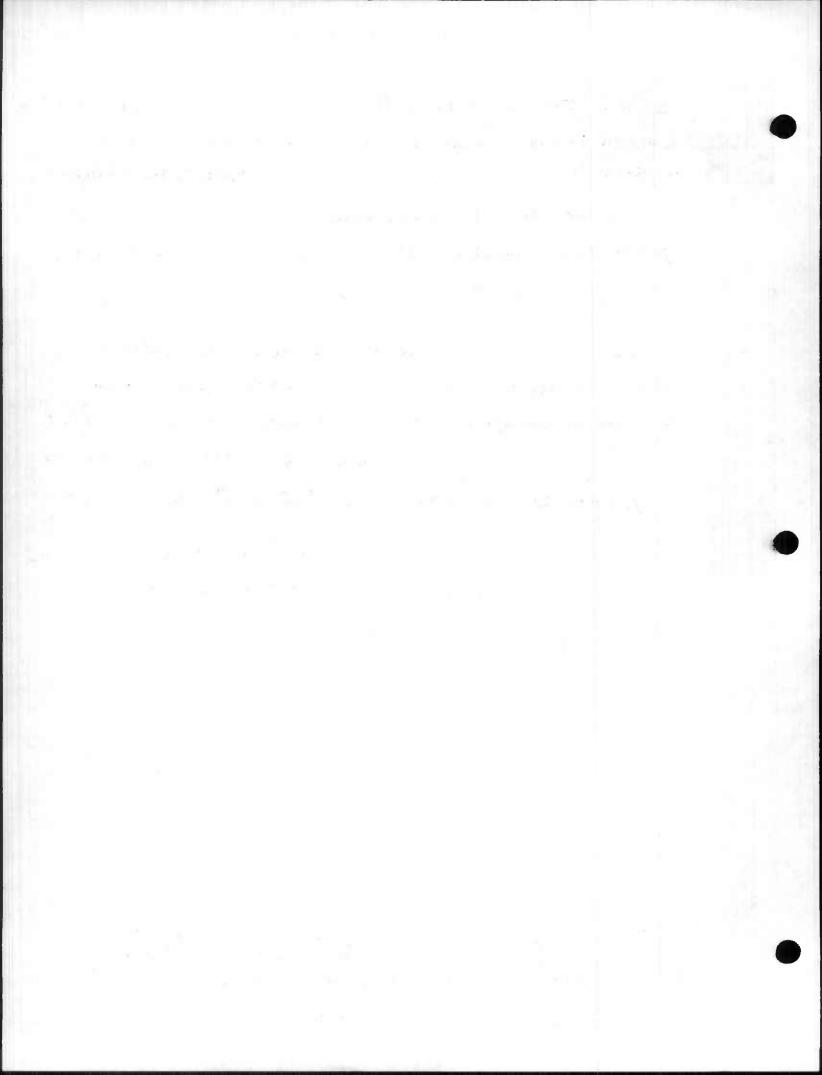
State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** Sept JR. EIMER ThomAS LANE 9:48 a.m 1998 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner County General Hospital Westminster CARROLL 7. Age (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number ·6. Sex Birthplace (State or Foreign Country) **Funeral** Year) 1 M 2□ F 212-42-6871 55 Yrs. 19,1943 MAKYLAND Director Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits T is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exerting must be notified at ARUNDEL Yes 2 No ANNE Director MD Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8850 Smallwood Kd. FORT 21122 United States Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yas 2 ☒ No
If Yes, Give
Yaar or Dates: Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Interportant: If term 27 is marked other than "natural", or have injury or other traument. 1 □ Naver Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Defense CRYPTO MATERIAL CONTROller 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be JAME WATSON Edith Thomas LANE, SR Elmer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 84 LONGWELL Avenue, Westminster MARY Ellen Schaffer/cousin MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriai 2 ☑ Cremation 3 ☐ Ramoval from State 5/98 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATORY HAMPSTEAD, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility MYERS FUNCEAL HOME 23a Part /Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, but, or heart failure. List only one ceuse on each line. 21157 West minster MD Approximate Interval Between Onsat and Death **Physician** RESPIRATORY FAILURE /Medical Immediata Cause (Final disaasa or condition resulting in death) Examiner Examiner MUSCULA physician end the burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury that Initieted events resulting In death) Last P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 98 USB Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 ☐ Y88 2 💢 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings aveilable prior to 24e. Was an eutopsy performed? Completed completion of cause of death? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours effer death.

To the Funeral Director: After this certified completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ↑ Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 2 1 ☐ Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Place of Injury - At home, ferm, streat, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledga, daath occurred at tha tima, date and place, and due to the cause(s) and mannar as stated.

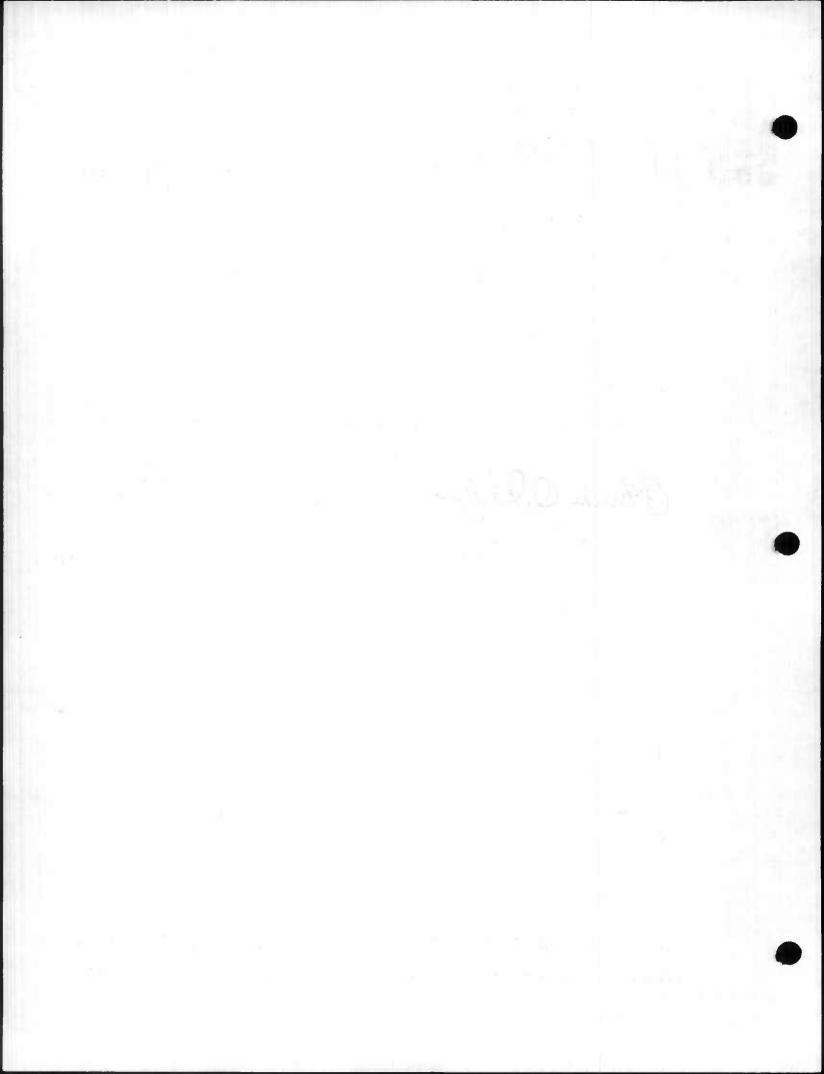
Medical Examiner: On the best of axamination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifia: 29b. Signature and title of pertiller 29c. License number 29d. Date/signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON HTS. WESTMINSTER PARA 21157 31. Dete filad (Month, Day, Year) 32. Registrar's Signeture

State Registrar



State of Maryland / Department of Health and Mental Hygiene

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31 Date tiled (Month Day Voor) 32 Pagletrade Sleneture			30. Name end eddress of person who KANAN HUDHUD.	completed cause of c	deeth (Item 23d	e) (Type, Print) House	AVE.					
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dev 9, REMBERT LEWIS, 1998 11:55AM **JEROME** SR. Sept. 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Talbot The Memorial Hospital Easton If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 15 M 2□ F Months Deys Hours Yrs. 220-09-6248 84 NOV.30,1913 MARYLAND Usual Rasidence of Dacedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 □ No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 802 DOVER ST. 21601 IISA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: WHITE Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondery (0-12) 8 -0-SERVICE TECHNICIAN PROPANE GAS COMPANY 18. Mother's Nama (First, Middla, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) JAMES COLUMBUS LEWIS MARTHA ELLEN WEST 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19e. Informent's Name/Ralationship (Type, Print) RONALD L. LEWIS/ SON 2809 CHANCELLORS PT. RD., TRAPPE, MD 21673 20b. Plece of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) JR. ORDER CEMETERY 9-12-98 PRESTON, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one ceusa on aech lina. Approximate Intervel Between Onset end Deeth Immediata Causa (Final diseese or condition resulting In deeth) Gangrene o Due (or es e consequence athersendo Dua to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ion body myositis 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only ona)

Physician /Medical Examiner Examiner

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page 2

Physician/Medical

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Completed

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Certification:

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requires that the death certificate be axecuted

Box 68760.

Division of Vital Records, P.O.

or Attending Physician:

After this funeral

after death.

24 hours a Hospital

To the Hosp within 24 ho To the Fune completely fi

Physician

/Medical

Examiner

MD

Director

Funeral

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Funeral

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7 is marked other than "natural", or ferms 23s or 28s-f show traumstic event, fire Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Introortant: If Item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Expenses.

Lewis, Rembert Maryland 21215-0020

Baltimore.

with the Maryland

death

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated avants resulting in deeth) Lest

Part II. Other signiffcant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

25. Was case referred to medical axaminer? 1□ Yes 2□ No 27. Menner of Deeth

2 Accident

3 Suicide

4 Homicide

28a. Date of Injury (Month, Dey Year) investigation

Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Tima of 28c. Injury at Work? 1 Yes 2 No

28d. Dascribe how injury occurred

29a. Cartifiar (Check only one)

5 Pending

6 Could not be determined

Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signeture end title of certifier

Robert W. Triever, M.D.

9-9-98

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end eddress of person who completed cause of deeth (Itam 23e) (Type, Print)

ROBERT W. TREVER, M.D., 7696 OCEAN GATEWAY, EASTON, MD 21601

28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify)

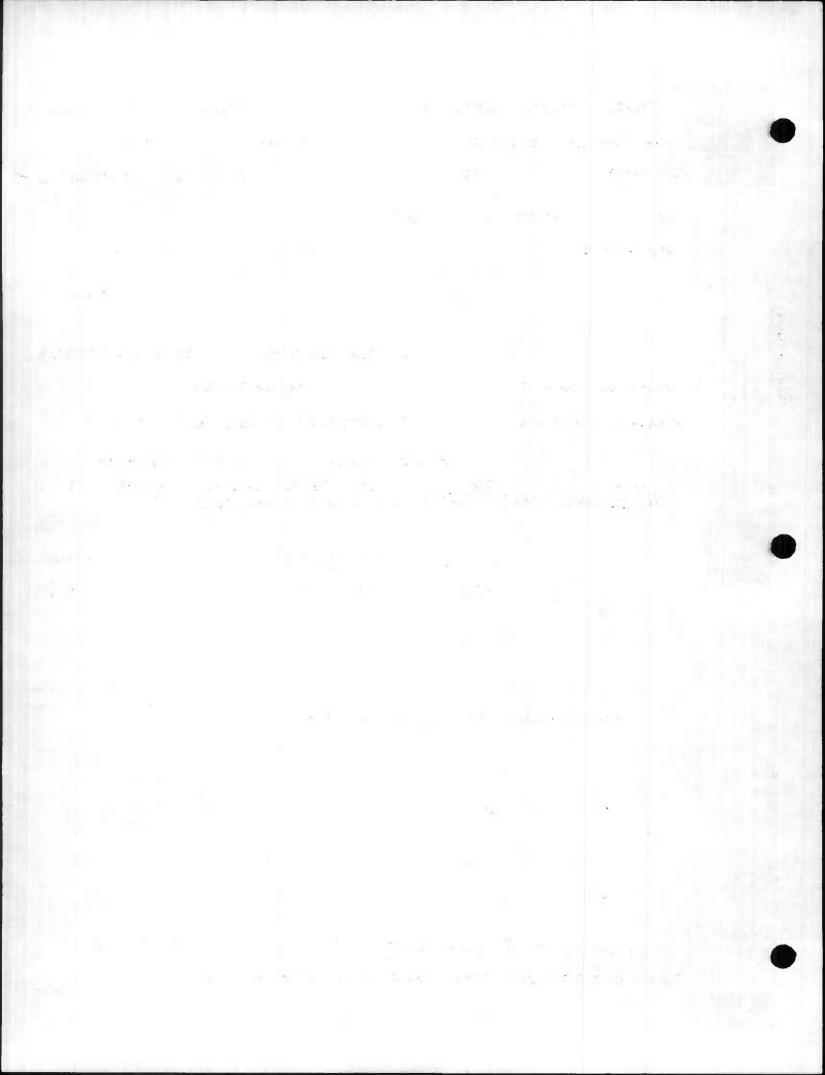
State Registrar

31. Date filad (Month, Day, Year) SEP

1 0 1998

32. Ragistrer's Signeture

South



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Raymond Linwood Lusby September 7, 11:10p.m. /Medicai 4a. Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10300 Augustine Herman Highway (Residence) Chestertown Kent If Undar 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) 7. Aga (In yrs. last birthdey) If Under 1 Yaar Months Days 5. Social Security Number Birthplaca (Steta or Foraign Country) **Funerai ™** 2□ F 215-36-0679 58 Director Chestertown, MD Usual Residence of Decadent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Macical Examinat must be recitled at 1 Yas 2 No Director Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10300 Augustine Herman Highway U.S.A. Funeral 21620 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Navar Married 2 Married 1 Yes 2 No If Yes, Give Year or Datas: 1 ☐ Yes 200 No Specify: by Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within Depertment of Health end Mentel Hygiene. Important: If tem 27 Is marked other than any injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Edward Brian Lusby Emily Sutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) B. Jean Lusby/Wife 10300 Augustine Herman Highway, Chestertown, MD 21620 20b. Place of Disposition (Neme of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Chester Cemetery/September 11, 1998 Chestertown, Maryland 21. Signatura of Funeral Service Licensae 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory drest. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final Central Nevvaus System Sarcoid osi's 20+45 disaasa or condition resulting in deeth) Examiner Due to (or as a consequence of) physicien end the burial-transit Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Cryptococcal Maningitis He; Poriploral Downpathy; 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Spinal cord Atrophy Soizure D/O; HTN; Osteoporosis 24a. Was an autopsy performed? Completed the builtiple Skin Concors; He Multiple UTI's 2 to Cathe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) 1 Yes 20 No Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 2 Accident 5 Pending 1 Yes 2 No Invastigation 6 Could not be determined 3 ☐ Sulcida 28f. Location (Street end Number or Rural Route Numbar, City or Town, Stete) 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifiar 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29c. License numbar 29d. Date signed (Month, Dey, Year) D50996 of death (Item 23a) (Type, Print) Chester town, Md. 21620 100 Brown St. Studdard 32. Registrar's Signature 31. Date filed (Month, Dey, Yeer) State Registrar

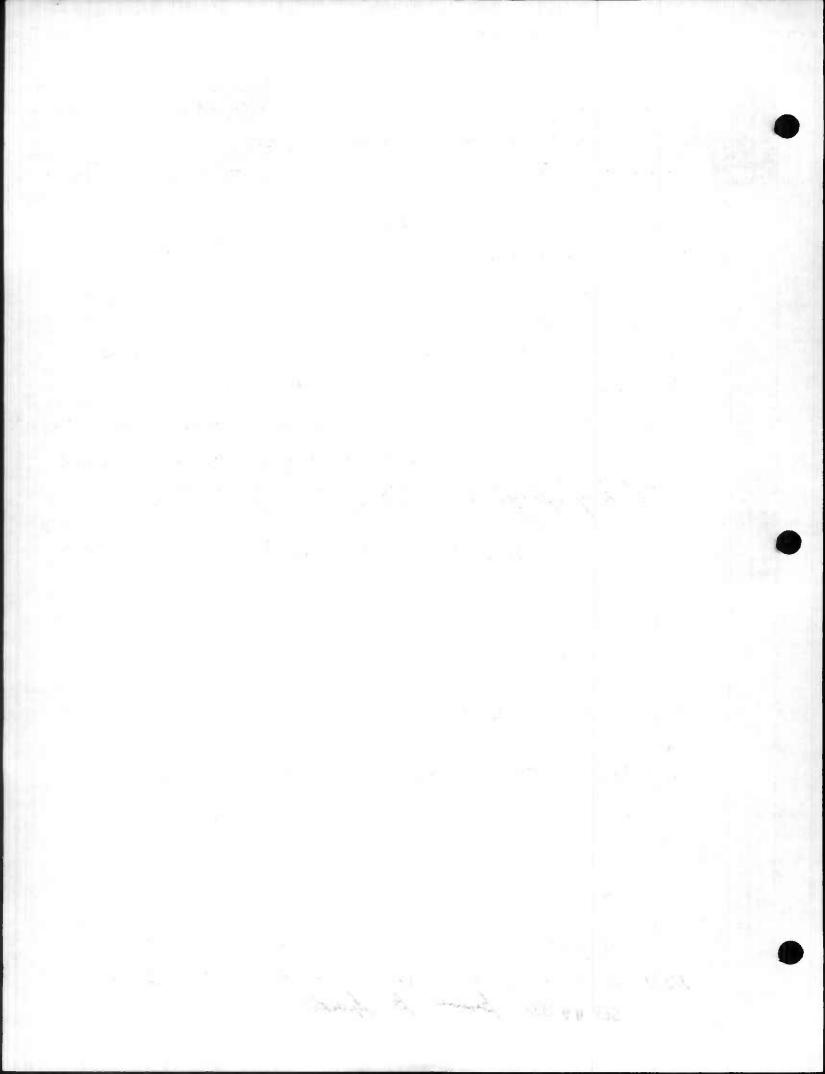
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the Meryland

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760.

Division of Vital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death September 7, 1998 0300 Harriet Jane Leidig 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Heron Point Care Facility Chestertown Kent If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2 F Days Months 182-22-6060 76 December 18, 1921 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Kent Yes 2□No Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 227 Heron Point 21620 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Biack, White, etc. 1 Never Married 2 Married 1 ☐ Yes ŽQNo Specify: 3 Widowed 4 □ Divorced Specify: White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oregin E. Donelson Hilda A. Blair 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott D. Leidig / Son 321 Farwell Road, Chestertown, Maryland 21620 20b. Place of Disposition (Name of cometery, crematory or other place) September 8, 1998 oc. Locetion - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chester, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center, LLC 21. Signeture of Funeral Service Licens 22 Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. William L. King, Jr. 130 Speer Road, Chestertown, Maryland 21620 23a. Part1. Enter the disease, or complications that cause leeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line Approximete Onset and Deeth Interval Bet Immediate Cause (Final disease or condition resulting in death) confos THE IteranT Due to (or as a consequence of): IscHamic complomyanty Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that leithed events.) Due to (or as a consequence of): TYPE 2 DIMBETOI MORCIRA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

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other traumatic evant, the Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If New 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Exercise once.

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760.

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Part II. Other significant conditions	contributing to death but not re	esulting in the underlyin	g ceuse given In Part I.	23b. Did tobecco uae co	ontribute to the cause of death
			8	24a. Was an autopsy performed?	24b. Were autopay findings available prior to completion of cause of death?
				1 ☐ Yes 2 KNo	1 ☐ Yes 2 ☐ No
25. Was cese referred to medical examiner?			26. Place of D	eath (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence 8 ☐ Ott	ner (Specify)
27. Manner of Death 1 Matural 5 Pending 2 Accident investigat		28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occur	rred
3 Suicide 6 Could not determine		home, farm, street, fact hifty)	cory, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,
29a. Certifier 1 Certifying (Check only one)	Phyalcien: To the best of my kn eminer: On the basis of examin	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, deeth occ	ce, end due to the cause(s) and mo curred at the time, date and place,	anner as steted.

State Registrar 31. Date filed (Month, Day, Yeer) SEP 08

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signeture and title of certifier

John C. Seymour, M.D. 122 Speer Road, Chestertown, MD 32. Registrar's Signature

my

29c. License number

10-13424

21620

29d. Date signed (Month, Day, Year)

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To the Hospital or Attending Physician: White 24 hours steed edge within 24 hours a steed edge. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (29a. Certifier (Check only one)	Certifying Phys	ician: To the be	est of my kno s of examine stated.	owledge, deeth etion end/or Inv	n occurred at the	ne time, date and pled my opinion, deeth occ	ce, end due to the curred et the time,	cause(s) end me date and pleca,	enner es s end due l	tated. the cause(s)		
Vithin Vi	29b. Signature and	title of certifier	IIII		1		cansa number		SOFAM	ed (Month, Day, Year) WIN 5 1998				
,	30. Neme end edd	ress of person who co	mpteted cause	of deeth (tter	m 23e) (Type,					- 01	1	1 0		

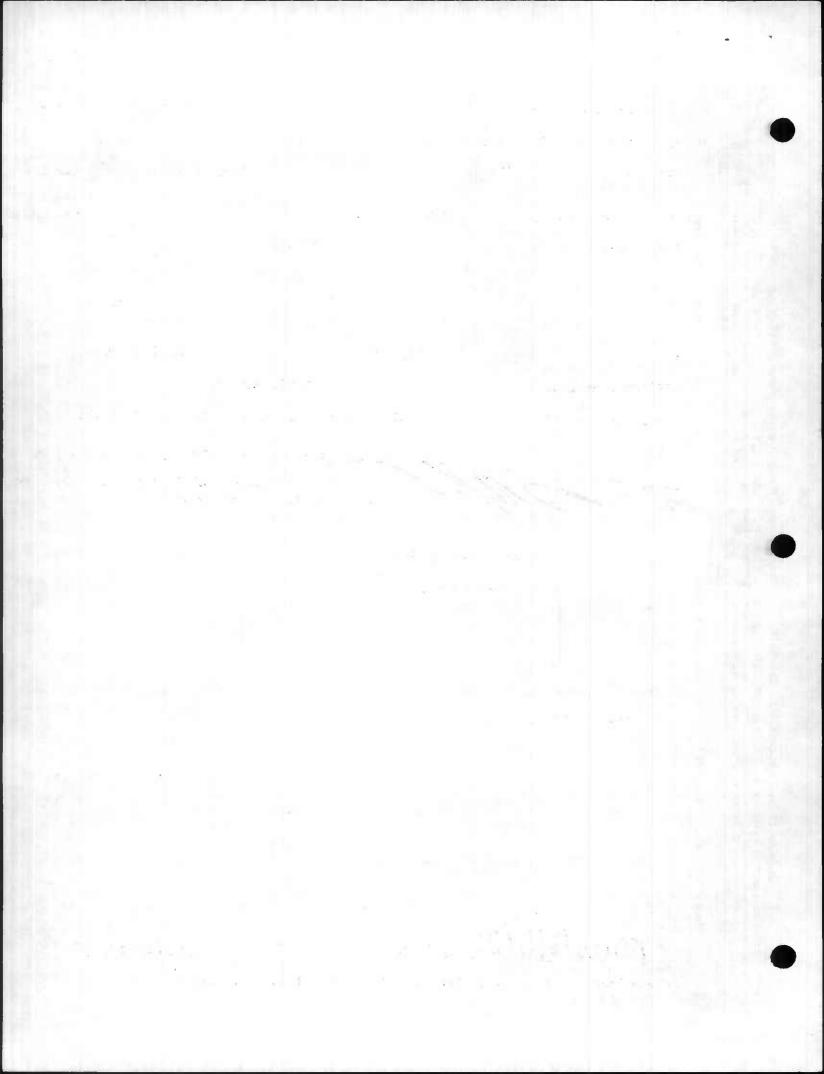
State Registrar

ブル Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

31. Dete filed (Month, Dey, Year) SEP 0 8 1998

Pamela Mulshine M.D. 11251 Lockwood Dr. Silver SPring, MD 20901 32. Figs strer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth 1998 **Physician** 1955 mc Kee 50 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deat Examiner Park Carroll Are Takoma mon STOLLE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State of Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dev. Year) 7. Age (In yrs. last birthdey) **Funeral** 1DM ANE Months Days Hours Min. 71 Yrs. 577-32-0341 Feb. 18, 1927 Director Illinois Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at NYes 2□No Montgomery Maryland Director Takoma Park 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7051 Carroll Ave. #305 Funeral 20912 U.S.A. 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiana. Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes ZHNo Specify: White Specify: þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) computer consultant self employed 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Lest) William C. McKee Sadi Soukup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Julie Tarr/niece 733 Springloch Rd. Silver Spring, MD 20904 other 1 20b. Plece of Disposition (Name of cametery, cremetery or other plece) No Virginia Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial XXCremation 3 Remeval from State 6 Sept. 3,1998 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Takoma Funeral Home, Inc. Squature of Funeral Service Licens 254 Carroll St. NW Washington, DC 20012 Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart takens. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) arr ac Examiner Examiner physician and the burial-transit that the death cartificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Due to (or es a consequence of): signed by tha a d be datached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to Completed 24a. Was en autopsy performed? completion of cause of death? has 2 No 1 ☐ Yes 2 ☐ No Attending Physician: funaral director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b Time of 28c. Injury at Work? 5 Pending investigation daath. 1 Yes 2 No 2 Accident or Attendiate dath 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the bar is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760 Hospital
 24 hours a
 Funeral D

> State Registrar

31. Date filed (Month, Day, Year)

29b. Sidu

09

are and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

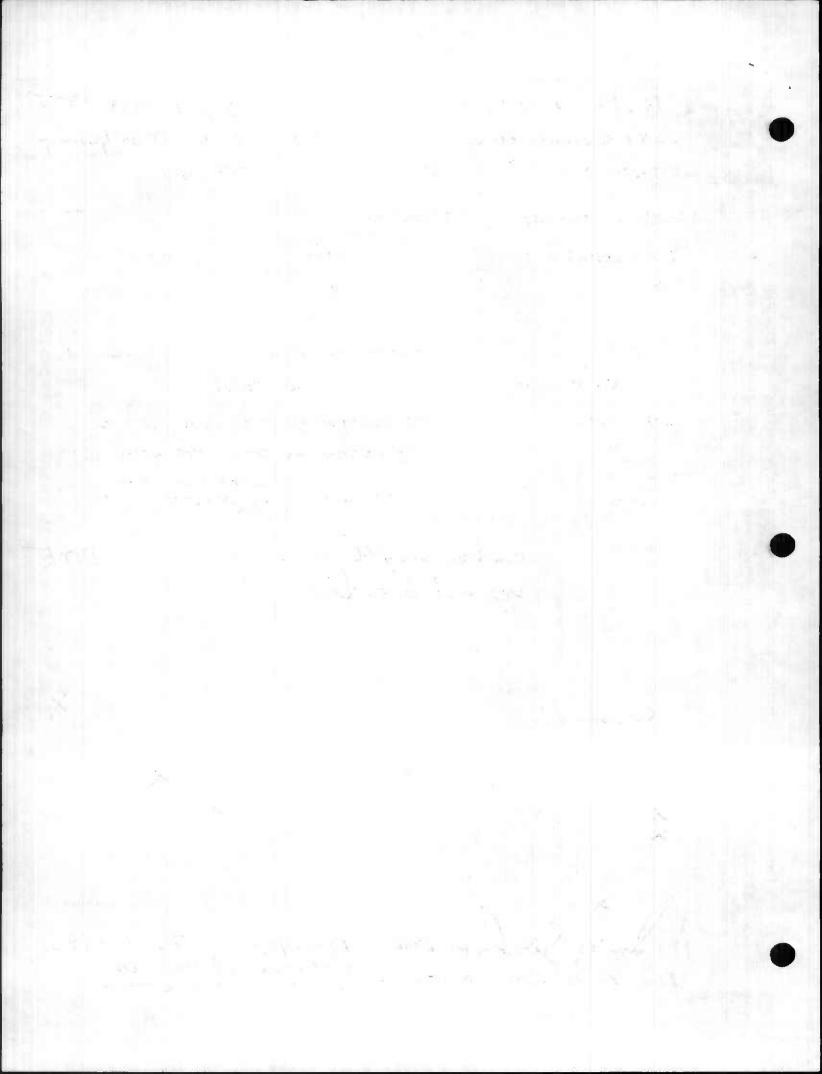
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29c. License number

29d. Dete signed (Month, Dey, Year)

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To the F



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day **Physician** Yeer Sidney Z. Mensh Sept. 1998 7:00pm 6, /Medical 4e. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Montgomery Bethesda 4936 Sentinel Drive 8. Date of Birth (Month, Dey, Year) Peb. 22,191 Washington, 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 □ F 578-05-6405 Yrs. Director 85 Usuai Residenca of Decedent D,C, the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "netural", or itams 23a or 28a-f show the Maxical Expresser must be notified at 1 S Yes 2 No Director Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 4936 Sentinel Drive 20816 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ↓ Yes 2 □ No If Yes, Give Yeer or Detes: WWII 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: by Specify: White 3 Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important: If flem 27 is marked other that any injury or other transmission. Real Estate Self-Employed Baltimore, Maryland 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Rose Clayman Shea Mensh 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rose B. Mensh /wife 4936 Sentinel Dr. Bethesda, MD 20816 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Adas Israel Cemetery 9/8/98 Washington, D.C. 22. Name and Address of Fecility
Ives-Pearson Funeral Home
2847 Wilson Blvd. Arlington, VA 22201 21. Signature of Funeral Servica Licanspe 23e. Part1. Enter the diseese, or comshock, or heart feilure. List only icetines III at caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, no contact a each line. Approximate Intervei Between Physician Onset end Death MY DENDIAL INFARCTON Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examin The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai the Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings evallable prior to 24e. Wes en autopsy completion of cause of deeth? hes certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Dev Year) Certification: 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 1 Maturel 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

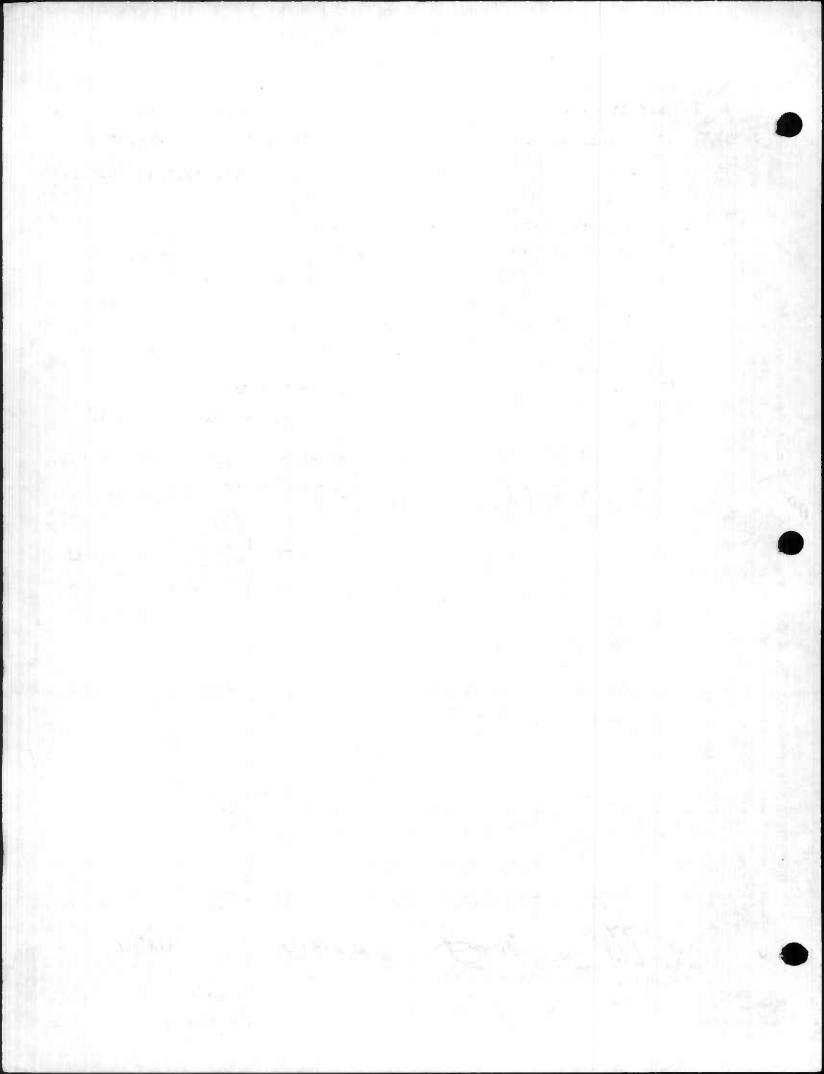
To the Funeral Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 D Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pieca, end due to the ceuse(s) end manner es stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end piace, and due to the cause(s) and manner stated. (Check only one) 29b. Signaturg.and 3 29c. License number 29d. Date signed (Month, Day, Year) 139456 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Dr. Lila McConnell 2 Washington Circle Chevy Chase, MD

Registrar

31. Date filed (Month, Dey, Year) SEP 1 0 1998

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #8,9/9/98, BMW, Montg. Co. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day Year September 2, 1998 RUTH VIRGINIA MOXLEY 11:50 pm 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth TAKOMA PARK MONTGOMERY WASHINGTON ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 1910 Sirthplace (State or Foreign 1□M 2N F Months Deys Hours 579-46-3572 Yrs August 14, 1998 VIRGINIA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY TAKOMA PARK MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 USA 116 LEE AVENUE, APT. 214 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian. 11. Merital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Private 8. Mother's Name (First, Middle, Meiden Surname) FRANCES GREGG 17. Father's Neme (First, Middle, Last) ARTHUR ARNETT 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MARY MOXLEY/DAUGHTER 116 LEE AVENUE, TAKOMA PARK, MD 20b. Place of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State FOREST HILLS MEMORIAL CMTY SEPTEMBER 5, 1998 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TAKOMA FUNERAL HOME, 254 CARROLI STREET, N.W., WASHINGTON, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death)

Physician /Medical Examiner

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P.O. Box 68760.

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Division of Vital or Attending Physician: Physician

Examiner

Funeral

Director

? Is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Medical Examinar mant be notified at

72 hours after

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Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy, Important: If item 27 is marked othe any Injury or other treumatic svent, bace.

Baltimore, Maryland 21215-0020

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Funeral

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Examiner attending physician end for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical 98

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown

24a. Was an autopsy performed?

24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yes

1 ☐ Yes 2 ☐ No

26. Plece of Death (Check only one)

5.	Was ce	se refe	red to me	dical
	V. 7	s 2	No	
7	Magher	of Deal	th	
	Nat	ural	5 □ P(endina

10 Inpatient investigation

28b. Time of

DME

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only

2 Accident

3 ☐ Suicide

4 | Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as steted. Medical Examiner: On the back of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and makiner stated.

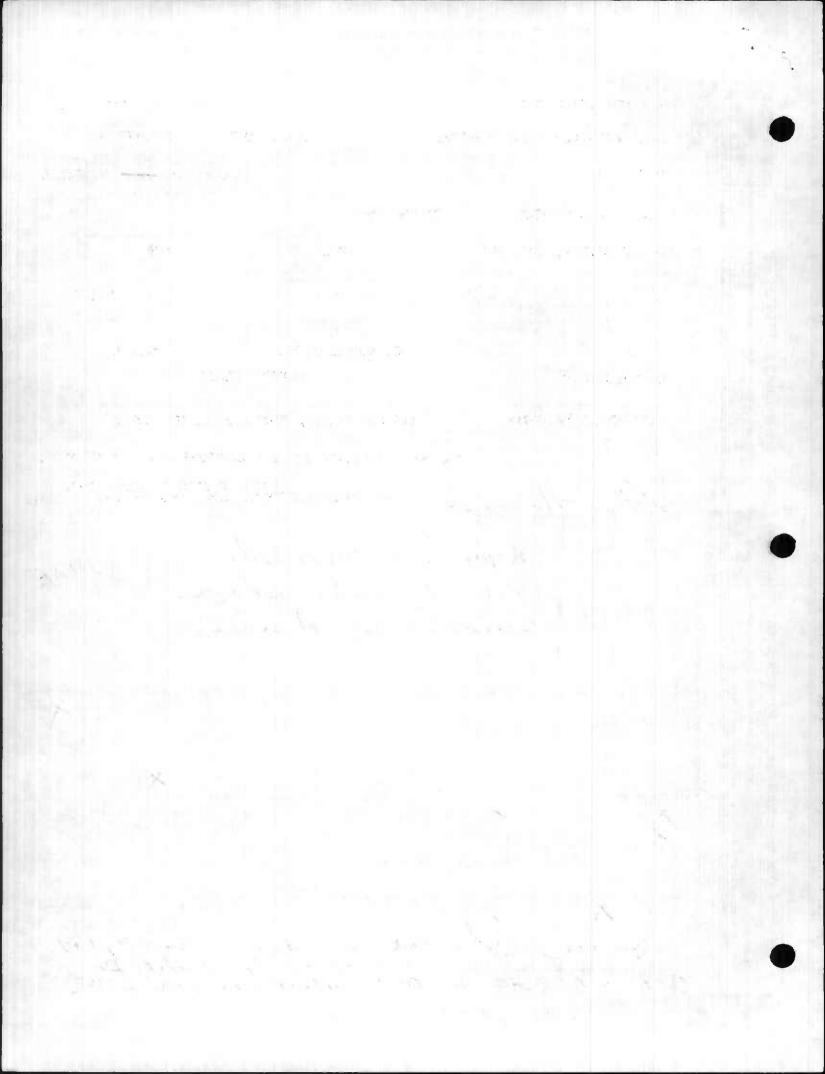
6 Could not be

29c. License number

29d. Date signed (Month, Dev. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 medical Park , hop BRECHER OMA

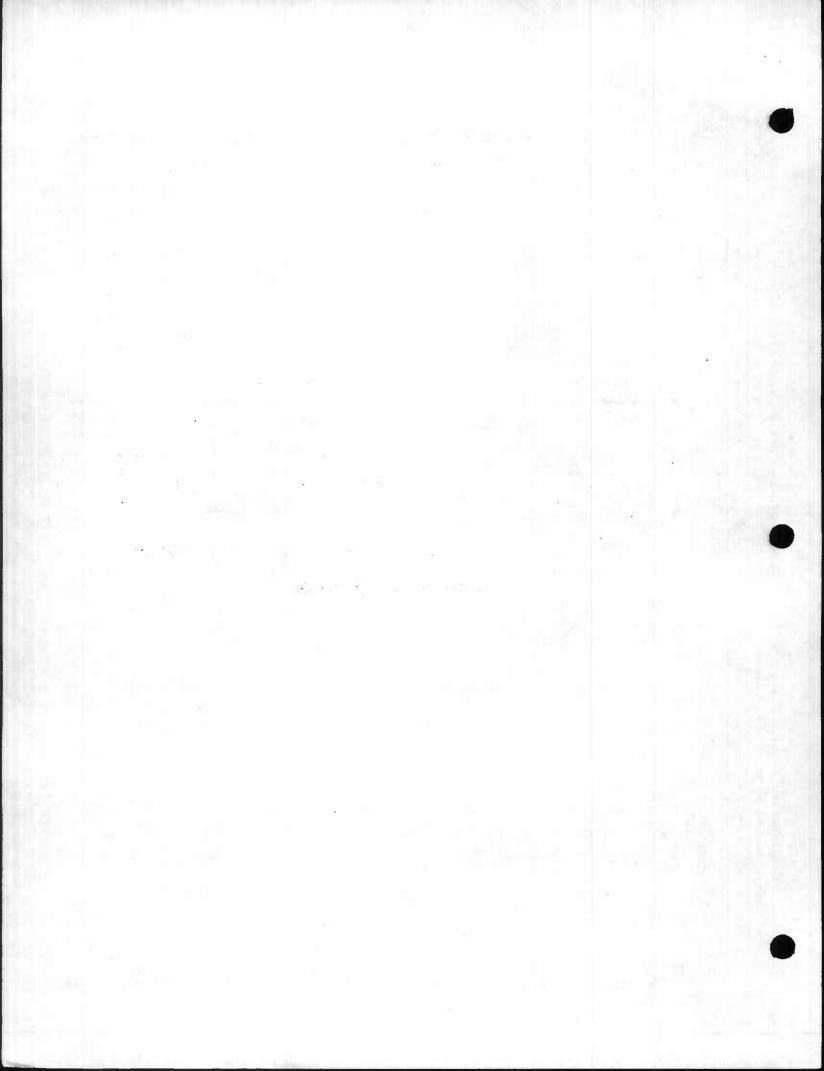
State Registrar P 0 9 1998 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5, 1998 September 10:10 PM Angela Mowbray Muir /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 15, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1 ☐ M 2 🖾 F 75 Yrs. 217-14-4804 Maryland Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1X Yes 2 No Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 739 Anderson Avenue 20850 United States death v Funeral 14. Rece - American Indian, Black, White, etc. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) e filed within 72 hours after d sl Hygiene. other than "natural", or fter 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be in nent of Health and Mentel Int: If Item 27 is marked or Thomas Mowbray, Jr. Marie Footen 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) James Gordon Muir, Jr. /Husband 739 Anderson Avenue, Rockville, Maryland 20850 20b. Piace of Disposition (Name of 20c. Location - City or Town, Stete Place of Disposition (reme of cometery, cremetory or other place) September 9, 1998 Dete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service License 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, M00689 Rockville, Maryland 20850-2805 the light salure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Firm Obstactive VerlilAtory Ofseese diseese or condition resulting in deeth) Examiner Edform Examine Bluower) physicien end s the burial-transit that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 15 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed has page 1 Yes 2 No 1 Yes 2 No certificate of Vital Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To this 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Affer Division Attending 1 Neturel 5 Pending investigation To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 🏗 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 2 044157 September 6,1998 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) ROAD, ROCKVIlle, MANYAND 20851 11in eris pos IRA BERGER MID. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 8 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** Theresa September 4, 1998 9:50 PM Evelyn /Medical Mann 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Manor Care- Potomac Potomac Montgomery If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) **Funeral** Months 1 □ M 28 F Yrs. May 3, Director 075-18-1222 1922 76 Florida Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Berra 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 10130 Darmuid Green Drive 20854 Funeral United States 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. hours after 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Datas: 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yas 2 ☑ No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced Black. Completed 16a. Decedent's Usuat Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) Practical Nurse Nursing permit, Pages 1 and 2 should be fits Department of Health and Merial Hy Important: If them 27 is marked oth any injury or other traumetic event 17. Fether's Neme (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Lemuel Delaney Willie McCleary 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Cecelia Ross/Daughter 10130 Darmuid Green Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of comatary, cremetory or other place) September 14, 1998 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Calverton, 4 ☐ Donation 5 ☐ Othar (Specify) Calverton National Cemetery New York 22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01126 not eations that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory errest, one causa on each line. Approximate Interval Between Onset and Death 23a. Part I. Bryt **Physician** /Medical Immediata Ceusa (Final Sepsis disease or condition rasulting in deeth) Examiner Due to (or as a consequence of): Examiner sician and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Causa (Diseasa or Injury that initiated evants resulting in daath) Lest Dua to (or as a consequence of): physician s the buria Box 68760. Physician/Medical Dua to (or as a consequence of) S 9SD signed by the e P.0. Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cerebrovascular Disease Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Diabetes Mellitus page 2 1 Yes 2 No 1 Yas 2 No Chronic Aspiration Division of Vital Physician: Be 25. Was casa rafarrad to medical axaminar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funerai 28d. Describe how injury occurred 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? or Attending 1 St Natural 5 Panding invastigetion 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stele) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 4 ☐ Homicide filled in Hospital Medicai 29a. Certifier 🖎 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) To the vithin 2 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number D38781 September 8, 1998 30. Name end address of person who completed cause of death (flem 23a) (Type, Print) Michael J. Grady, M.D. 4910 Massachusetts Avenue, N.W. #312, Washington, DC 20032

Registrar **DHMH 16 Rev 6/95**

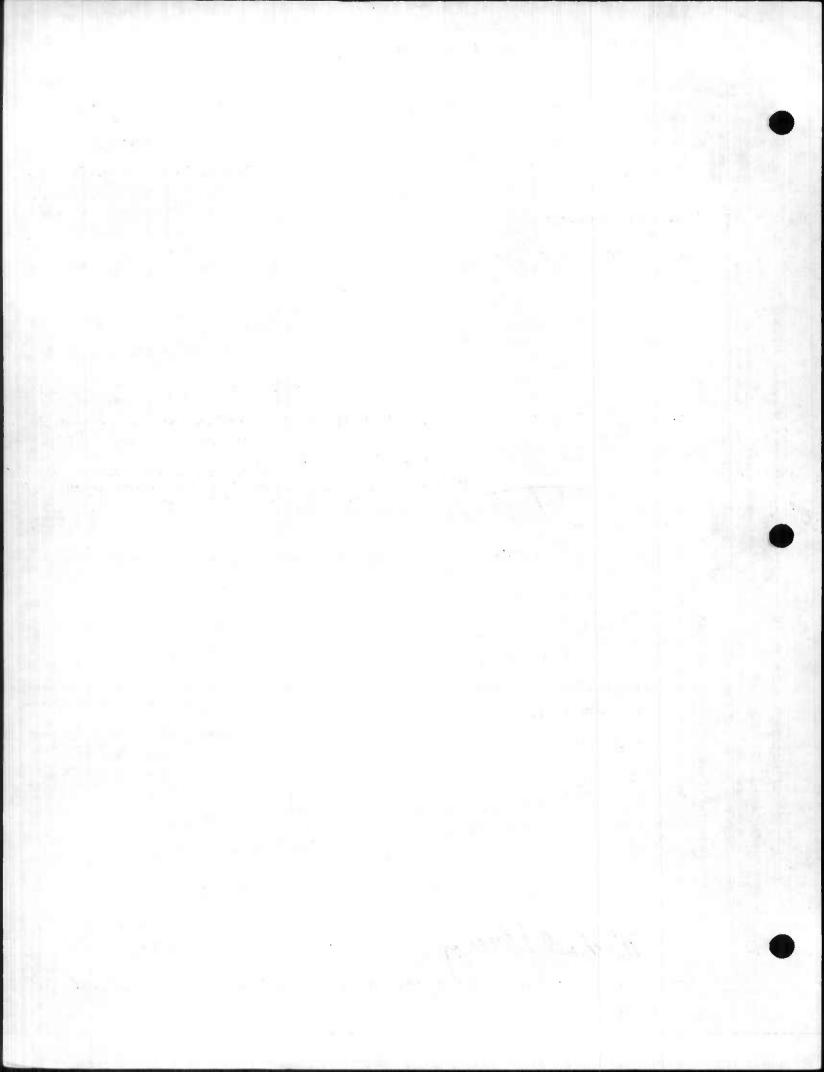
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31. Data filed (Month, Day, Year)

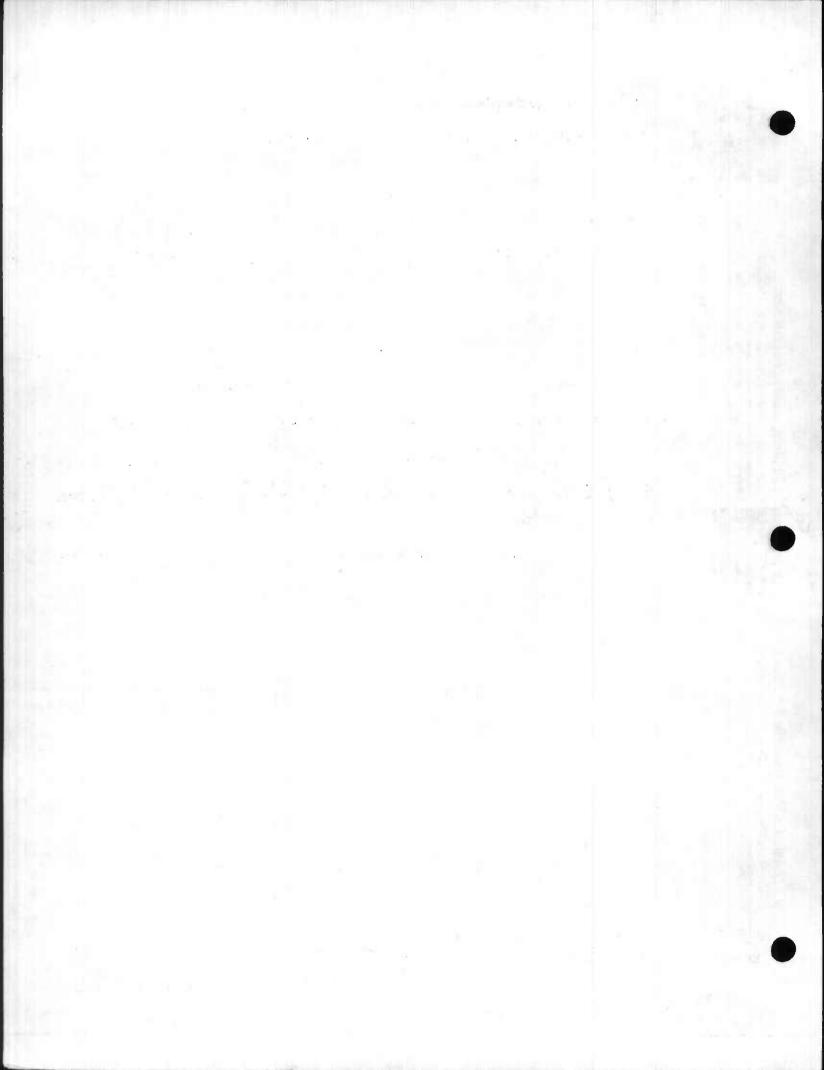
32. Registrer's Signatura

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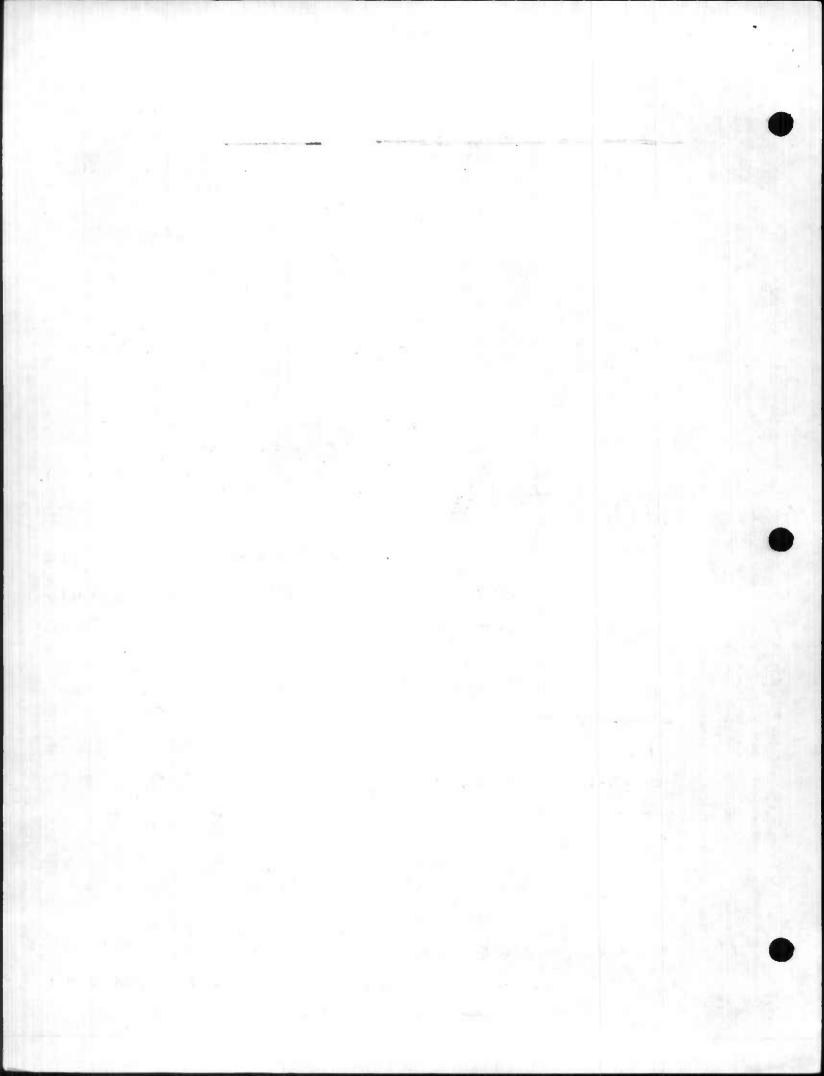


State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate of	f Death		Reg. No.	29055
	DI	1. Decedent's Name (First, Middle, Las	t)				2. Date of De		3. Time of Death
	Physician /Medical	Theophilos N	Nicolas Mats	angakis			Septembe		98 7:35 P.M.
	Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, o	or Location of Deat	h 4c. County o	Death
1		12203 Braxfi	eld Court #1	.0	Her. 3.	Rockvil:	le	Montgo	mery
	Funeral Director	5. Social Security Number 6. Security Number 217-90-5928	9x ▼ 7. Age (In ▼ 86	yrs. last birthday) Yrs.	Months Day			th iy, Year) 30, 1911	9. Birthplaca (State or Foreign Country) Greece
	P.	Usual Residence of Decedent	Lan	0: 7: 1					
	Maryla I ahov	10a. State 10b. County Maryland Montgome		Rockvil					10d. tnside City Limits 1 ☐ Yes 2 🖔 No
	h with the Mai 13a or 28a-1 a at be nothled	10e. Street and Number 12203 Braxfield	Court #10		101. Zip Code 2085			10g. Citizen of Wi	nat Country?
020	within 72 hours after death with the Manyland ena. The "neturel", or items 23s or 28s-7 show the second comment of mothlad a mpleted by Funeral Director	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🔯 No		(Specify Yes or No erto Rican, etc.)	14. Race Bleck, Specify:	- American Indian, , White, etc. White
2-0	"natural", and E	15. Decedent's Ed		16a. Dece	dent's Usual Occ	upation e during most of v	undring	16b. Kind of Bus	iness/Industry
Maryland 21215-0020	ed within 72 ho ygjena. er than "naturi ft, ms frederill Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Buil	DO NOT use reti	ed)	ion and	Construc	ction
D	三工会员	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle		
<u>a</u>	The second	George Matsang	akis			Irene	Economo	u	
ary	d 2 should th end Mer 7 is marke traumatic	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Stre	et and Number or	Rural Route Numb	er, City or Town, S	itate, Zip Code)
Σ	Health erm 27 is other trac	Pierre Matsangaki				ley Road	, Highlan	nd, Maryl	Land 20777
Baltimore,	Pegas 1 end ent of Health nt: If item 27 ry or other tr	20a. Method of Disposition 1 🖾 Buriel 2 Cremation 3 🗆 4 Donation 5 Other (Specify	Demoval from State	Ob. Placa of Dispo cametery, cre-	metory or other p	Septembere	10,1998		City or Town, State
Balti	permit. Pegas 1 and 2 Department of Health Important: If Item 27 I any Injury or other tri	1. Signature of Pluneral Service License	sbe 3	Re	2. Name and Add	ress of Fecility	ineral Home	/Rockville	
		23a. Part . Enter the diseese, or come shock, or heart failure. List only of	4						Approximeta
S.	Physician	snock, or neart failure. List only o	one cause on each line.						friterval Between Onset and Death
	/Medical	Immediate Cause (Final disease or condition	Abdomina	1 Carcin	amatosis				l Week
	Examiner	resulting in death)	a	to (or as a conse					1 WEEK
	je je								
ó	ficate be associted physician and is the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events	b. Due	to (or as a consec	quence of):				
,09/89	- 00	resulting in death) Last		to (or as e consec	quence of):	V			
ROX	et the death cerd by the attendin etached for use Physician/N		d						1
	he a he a sic	Pert II. Other significant conditions co	ntributing to death but no	t resulting in the u	inderlying cause (given in Part t.	23b. Did	tobacco use cont	tribute to the cause of death?
7	es that the death cer igned by the attendir be detached for use by Physician/A						10	Yes 2□ No	3 ☐ Probably 4 🖔 Unknown
Hecords,	been s should			BA	100		24a. Was perfo	an autopsy ormed?	24b. Ware autopsy tindings available prior to completion of cause of death?
Ĭ	The law ate has pege 2						10	Yes 2X No	1 ☐ Yes 2 ☐ No
Vital	certificate rector, per	25. Was case referred to medical				26. Place of D	Death (Check only)	one)	
>		examiner? 1 ☐ Yes 2 ☒ No	Hospital:	2 ER/Outpatie	nt 3 DOA	Wher	Home 5X Resi		(Specify)
io uo	ding Phy h. After this funeral o	27. Mannar ot Death 1 🖾 Natural 5 Pending Investigation	28a. Date of Injury (Month, Dey Yea	28b. Time o	28c. tnj		1	how injury occurre	
5	To the Hospital or Attending P within 24 hours after death to the Funeral Director. After completely filled in by the funeral Medical Certification:	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)				28f. Location (City or To	Street and Number wn, State)	r or Rural Route Number,
	Hospi 24 hour Funer stely fill		rstclan: To the best of my lner: On the basis of examend menner stated.						
	To the comple	29b. Signeture and title of certifier			29c. Lice	nse number		29d. Dete signed	(Month, Day, Year)
	1	Honor	a Si	Jus	1	D43083		Contombo	r 8 1000
	5	30. Name and address of person who c			Print)				er 8, 1998
	State	George A. Sotos, I	M.D., 9707 M 32. Begistrar's S		4), Rockvi	lle, Mar	yland 20850
	Registrar	SFP 1 1 1999			Look	61			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend #4b,9/14/98,BMW,Montg. Co per physycian Amend #4a,9/14/98,BMW,Montg.Co.per physician Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Month 3. Tima of Death Vear **Physician** McCarthy John September 4, 1998 9:48 AM /Medical 4a Facility Name (If not institution, give street and number)
10610 Falls Road
CHADY CROVE ADVENUETED 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Potomac MONTGOMERY 8. Data of Birth (Month, Day, Year) f Under 1 Year Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□ F 91 Yrs 067-09-4110 November 8, 1906 Director Ireland Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Director Maryland Montgomery Potomac 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 10610 Falls Road United States 20854 Funeral 14. Race - American Indian, Black, Whita, atc. 11 Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yas 2 No
If Yas, Give
Yaar or Datas: 1 □ Navar Marriad 2 □ Married altimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 NWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County Board filed within Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) of Education 12 Brick Mason other pemit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Itam 27 ta marked other any Injury or other traumatic accer-17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Daniel McCarthy Julia O'Neill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen P. Moriarty/Daughter 11702 Judson Road, Silver Spring, Maryland 20902 20b. Place of Disposition (Name of cemetary, crematory or other place) September 9, 1998 20a Mathod of Disposition 20c. Location - City or Town, Stata 1 ⊠ Burial 2 □ Cramation 3 □ Ramoval from Stata Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Silver Spring, Maryland 22. Nama and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service License le, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Rockville, Inc. Mu0689 Erflar haldiseasa, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** conjestive heart failure out to (or as a consequence or): atrial fibrillation /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last Bud Box 68760 physician stenosis aortiz Physician/Medical Dua to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. P.O. 94 2 3 Probably 4 Unknown 1 Yes 2 No osteoasthritic signed b Records, p 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed glavcoma completion of causa of death? page 2 benin prostatiz hypestrophy 1 Yes 2 PNo 1 ☐ Yas 2 ☐ No certificate Division of Vital 25. Was casa refarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 10 1 Yas 2 No this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b Time of Certification: 28c. Injury at Work? After 1 Matural Attanding 5 ☐ Pending death. 1 Tyes 2 No Invastigation aftar death Director: A 2 Accidant 6 Could not be datermined 3 ☐ Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida To the Hospital or within 24 hours after To the Funeral Dir completaly filled in 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. License number September 4,1998 33443 MO 30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print) 809 VIES mill Rd. Rockville, Md 20851 Pollack, m.D. 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State 0 8 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Septh 10, 6:37 am 1998 DONALD DALE MILLER /Medicai 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth Month, Day, Year 1917 Sex Birthplace (Stata or Foraign
Country) **Funerai** Months Days Hours Min 214-05-8653 Yrs. 81 Director Usual Residence of Decedent death with the Maryland Show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD Allegany Cumberland Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Furnace Street 21502 USA Funerai 12. Was Decedent Ever In U,S. Armad Forces? 1 ☐ Yas 2 No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter of the for the Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or item 1 Never Marriad 2 Married 21215-0020 1 Yes 2 No Specify: by Specify 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: white Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Textile Retired traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Melden Surneme) Vernon Miller Ethel (Kifer) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a informant's Hame/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trauonce. Margaret Martz-stepdaughter 728 Arundel Street; Cumberland, MD 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Hillcrest Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 09/14 Cumberland, MD 21. Signati re of Funeral Service Lice 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Part1. Enter the diseasa, or coron shock, or heart feilure. List only ications that caused the daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, essee on each line. Approximate Intervel Betw Onsat and Death Physician /Medicai Immediate Cause (Finel disaase or condition resulting in death) a. MYOCARDIAL INFARCTION ONE HOUR Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting In death) Last Bud the bunel-tran Due to (or as a consequence of): Box 68760. ettending physician Physician/Medicai Due to (or as a consequence of): been signed by the etter should be detached for a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 Yes 2 No ALZHEIMERS DISEASE, MITRAL REGURGITATION Division of Vital Records, Completed by 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? certificate 1 ☐ Yes 2 R No 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Deacribe how injury occurred 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homiclde To the Hospital within 24 hours e To the Funeral D Medical 29a. Certifier 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated. completely (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Hma Shan MO Sept. 12, 1998 D46346 6 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Huma Shakil; 625 Kent Avenue; Cumberland, MD

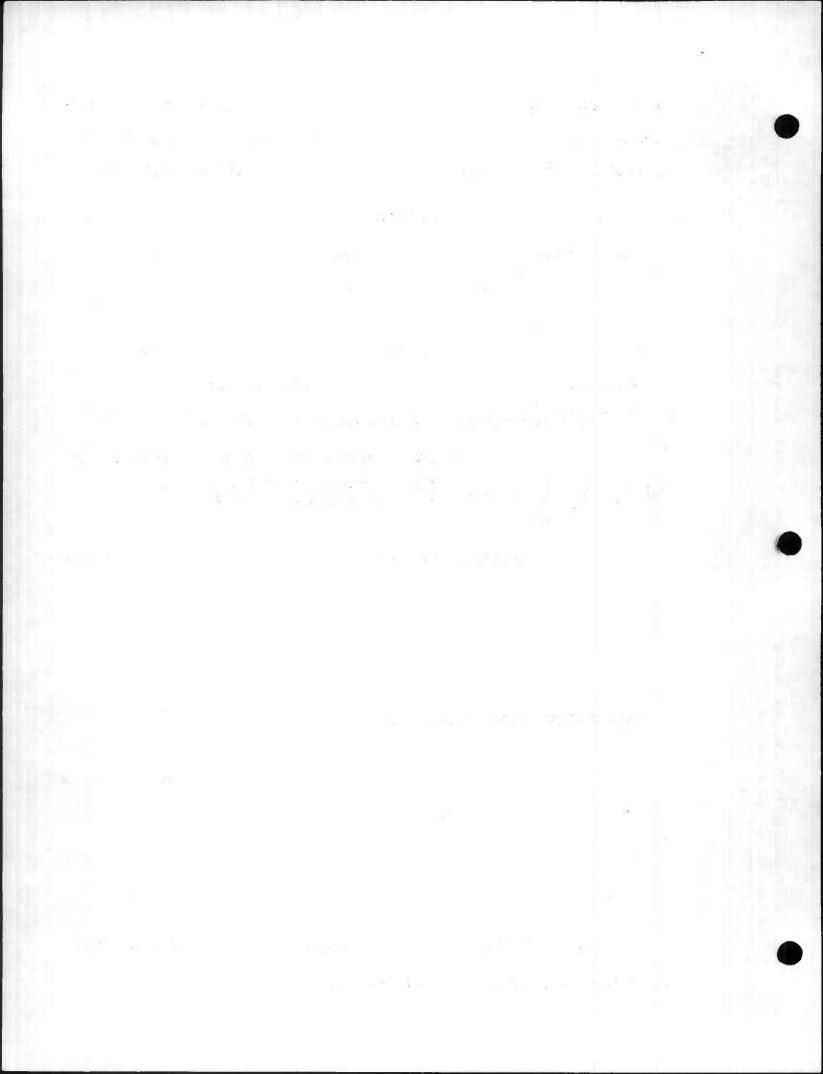
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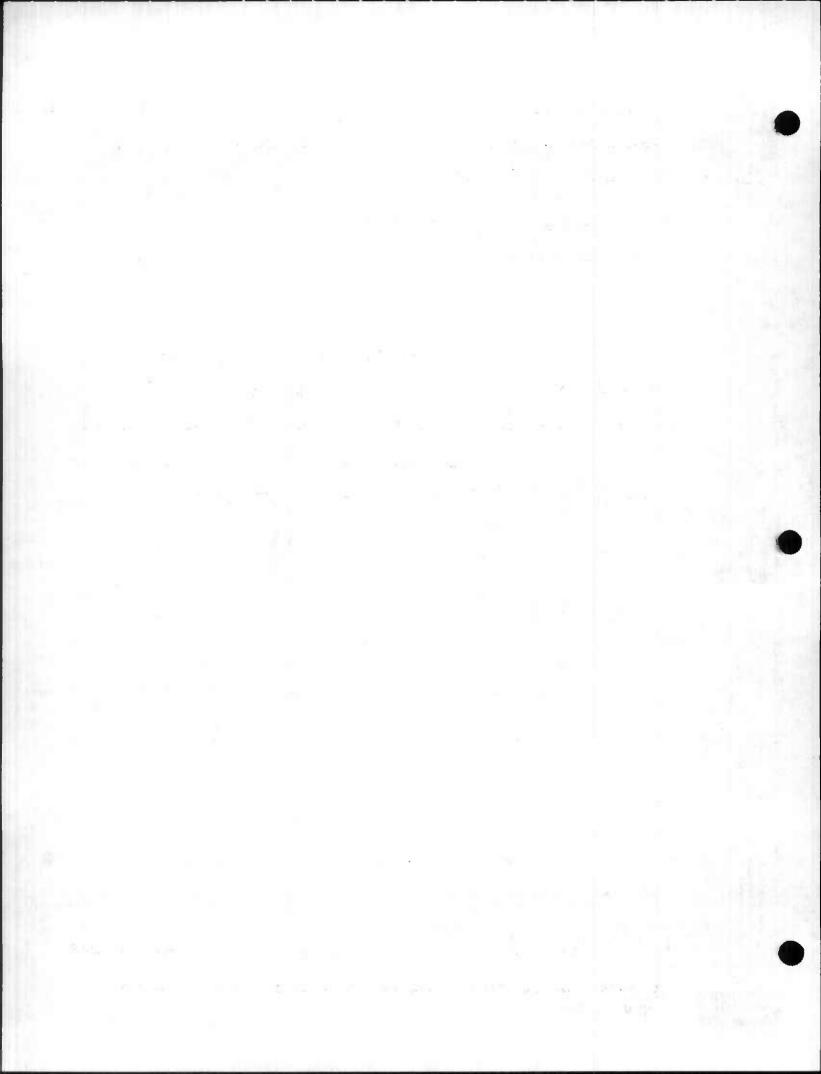
31. Dete filed (Month, Day, Year) SEP 1 4 1998 32/Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene

							-	rtificate o	f Death		Reg. No.	2	9058
ı	Physic	ian	1. Decedent's Name (F							2. Date of D Month	Dey	Yeer	3. Time of Deeth
e	/Medi		WANDA 4e. Fecility Neme (If no	A L. ME		ar)			4h City Town	Sep or Location of Dee		98.	1:30 pr
	Exami	ner	12806 TH			,,,							
H	Funeral		5. Sociel Security Number			Age (In yrs. lesi	t birthday)	If Under 1 Yea		Irs. 8. Dete of B	ALLEC		place (State or Foreign
L	Director		212-24-19 Usuel Residence of De	02	□M 2 <u>M</u> F	70	Yrs.	Months Dey	s Hours M	in. (Month, E	Dey, Year) 21, 1927	Cour	plece (Stete or Foreign htry)
	how		10a. Stete 10	b. County		10c. City, T	own or Lo	cation				1	0d. Inside City Limits
	8a-f s	Director	MD Z	Allegany	7	C	umbei	rland				ŀ	1 ☐ Yes 2 No
	or 2	Dire	10e. Street end Number	r				10f. Zip Code			10g. Citizen of V	het Cour	ntry?
	ath v	La	12806 Thu	rmel Dr				215			US.	-	
Maryland 21215-0020	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show to Madical Examinet must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		12. Wes Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	s?] No		Wes Decedent of f Yes, specify Cu 1 ☐ Yes 21 N	f Hispenic Origin? uben, Mexican, Pu o Specify:	(Specify Yes or Nerto Rican, etc.)	Io- 14. Race Blec Specify	k, White,	ean Indien, etc. white
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21	y within 7 piene.	npie	Elementery/Secondar	1	College (1-4o	(+6.1)				vorking			
12	73 70 20	Col	12 Fether's Name (Fire	at Adjudella I mask		F	Retire	ed Manag	_		Hospit		
and	S la b S	Be	17. Fether's Neme (Firs								le, Maiden Sumem	Θ)	
2	ges 1 end 2 should b it of Health end Ments If Item 27 la merked or other traumetic e	70	Jacob M. 19a. Informent's Name		vne Print)		10h Mailin	ng Addross (Stm.		(Gumm)	ber, City or Town,	Ctata Zin	Codel
Ma	end 2 s saith en n 27 la er trau		James E.	THIS CASE IN							berland,	11100	21502
re,	other tra		20e. Method of Disposit		-Husband	20b. Place	a of Dispos	sition (Name of netory or other p		Date Date	20c. Location -		
E	Pages nent of int: If It		1 XBuriel 2 □ Cr 4 □ Donetion 5 □			0			tery	00/17	Crambo o re	l and	MD
Baltimore,	교문문을 .		21. Signature-of Funery			/	//	Name end Add		09/17	Cumber	Tario	, MD
0	Deper Impo		MIDI	nn (b)	1 11	ainell	15	Scarpe	lli Fune	ral Home	, P.A.		
			23a. Part1. Enter the di shock, or heart fail	isease, or compi	cations that caus	ed the death. [Do not ente	er the mode of d	land, MD ying, such es card	lac or respiretory	errest,		Approximete Intervel Between
	Physician				9	W. W. C.						1	Onset end Deeth
	/Medical Examiner		Immediete Ceuse (Fina diseese or condition resulting in death)	ıl	MYDO	CARDI	AL	INF	ARCTI	00			F DAY
		-	resulting in death)			Due to (or es							
	nsit	Examiner			b								
ď.	execu in end iel-tra	Exa	Sequentially list condition if eny, leading to immediate. Enter Underlyin	ons, diate		Due to (or es	e conseq	uenca of):				i	
68760,	certificete be executed nding physician end use es the bunel-transit	edical	thet initieted events	y	0	Due to (or es	e consequ	neuce of).		^	- 0		
	\$ D 0	Med	resulting in deeth) Lest			(3.2					0 //	i	
Вох	eth cer ettendir for use	Physician/M			d					don	John	145	0713,1998
Ö	0 0 0	sic	Pert II. Other significan	t conditions cor	ntributing to deeth	but not resultin	g in the un	nderlying cause g	given In Pert I.	23b. Dic	d tobacco use con	tribute to	the cause of death?
P.O.	that the de led by the e deteched t									1	Yes 2 No	3 Prot	bably 4 Unknown
Records,	8 50	d by								240 We	s en eutopsy	24h We	ere eutopsy findings
200	v require been si should	Completed								per	formed?	COL	eileble prior to mpletion of cause
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tal	certificate rector, pag		25. Wes case referred to	o medical.					OF Blood of F		Yes 2 X No	1L	Yes 2□ No
of Vital		To Be	examiner?	2000	lospital:	tient 2□ER/	Outpetient	t 3□ DOA O	Whor	eeth (Check only	one) sidenca 8 □Othe	r (Specifi	v)
ion o			27. Manner of Deeth 1 Neturel 5	☐ Pending investigation	28e. Dete of In (Month, D	jury 28	b. Time of Injury	28c. Inj			how Injury occurre		,
Division	ai or Attanding s efter death. Il Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 4 ☐ Homloide	Could not be determined	28e. Place of li building, e	njury - At home etc. (Specify)	, ferm, stre	eet, fectory, office	a	28f. Location City or To	(Street and Number own, State)	er or Rura	l Route Number,
	To the Mospital or Attanding Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	edical (29a. Certifier 1	Certifying Phys Medical Examin	sician: To the bes ner: On the besis end menner s	of examinetion	dge, death end/or Inv	occurred et the estigetion, in my	time, dete end pla opinion, death oc	ce, end due to the curred et the time	e ceuse(s) end mei	nner es st nd due to	eted. the cause(s)
	To the To the Comp	ž	29b. Signature and title	of certifier	1	14.7		29c. Licer	nse number		29d. Dete signed	(Month, I	Dey, Year)
	7		18/	Danie	186			D1	4865		Sept.	14,	1998
	M 3- 3		30. Neme end address of	of person who co	empleted cause of	deeth (Item 23	e) (Type, F				-		
	MA		Dr. Robu	stiano J	Barrera;	Memori	al Ho	osp. Med	l. Bldg;	Cumberla	ind, MD 2	1502	
	Sta Registr		31. Dete filed (Month, De	4 1998		trer's Signeture	4	Spark	,				
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician September 5, 1998 Boyd Llewellyn MANN 11:12 A.M. /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Undar 1 Yaar If Under 24 Hrs. 6. Sex 8. Dete of Birth (Month, Dey, Year) Jan. 15, 1938 7. Age (In yrs. lest birthday) **Funeral** Birthplaca (State or Foreign Country) Deys 100 M 2□ F 60 Yrs. 213-34-5636 Director Maryland Usuel Residence of Decedent nit. Pages 1 end 2 should be filed within 72 hours after death with the Manylend definent of Health end Mental Hygiane. ortant: if flam 27 is marked ortant after 28 or 28 or 28 or 28 ortant in luly or other traumate event, in a Medical Exercitor man be notified as 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick Maryland Frederick Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5107 E Old National Pike 21702 U.S.A. Funeral 12. Was Decedent Evar in U.S. Amed Forcas? 1 Nes 2 Ne If Yes, Give Year or 18459 Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. Raca - American Indien, Bleck, White, etc. 1 Nevar Married 2 Married Maryland 21215-0020 1 Yes 2X No Specify: White Completed by Specify. 3 Widowad 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) Collage (1-4or 5+) Heating and Air 12 Technician Conditioning Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be 2 Carl C. Mann Marion Lowe 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 5107 E Old National Pike, Frederick, MD 21702 Mary Ann Mann/Wife Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Surlal 2 Cremetion 3 Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery Sept. 9, 1998 Frederick, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Keeney & Basford Funeral Home M00021 Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory errest, Interval Between Conset and Death Conse **Physician** /Medical Immediate Cause (Final disaasa or condition resulting In death) Examiner Due to (or es e consequença of): Examiner The law requires that the death certificate be executed signed by the attending physician and I be detached for use es the buriel-tran Sequantially list conditions, if eny, laading to immediata cause. Enter Underlying Ceuse (Disaese or Injury Due to (or as a consequenca of): Box 68760, Physician/Medicai thet initieted events resulting in deeth) Lest Due to (or es e consequença of) Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2□ No 3□ Probably 4□ Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? peen s Completed 24e. Wes en eutopsy hes pege 2 1 ☐ Yes 20 No this certificeta 1 ☐ Yes 2 ☐ No as or Attending Physicien: The start deeth.

In Director: After this certificet ed in by the funeral director, pr Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 10 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and pieca, end due to the cause(s) end manner stated. Medical (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and o completed cause of deeth (Item 23e) (Type, Print) SON Date filed (Month, Dey, Year) 32. Registrar's Signature State 0 8 1950

DHMH 16 Rev 6/95

Registrar

SEP

	ARY MANYEITE State of Maryland / Department Certificate		Reg. No.	
	1. Decedant's Nama (First, Middle, Last)		a of Deeth 3. Tima of Death	
Physician	Richard Gary Manyette	SEP	TEMBER 5, 1998 0555 AM	
/Medical Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of	of Death 4c. County of Death	
	6988 RUNKLES ROAD	MOUNT AIRY	Carroll	
neral ector	578-42-6515 64 Yrs.	Days Hours Min. (Mo	a of Birth nth. Day, Yaar) 9. Birthplace (Stata or Forei Country) 17, 1934 Washington, D	
-	Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location		10d. tnsida City Limi	ts
Examiner must be notified at	Maryland Carroll Mt. Airy		1 ☐ Yas 2 🖔 N	
Director	106. Street and Number 10f. Zip C	oda	10g. Citizen of What Country?	-
	6988 Runkles Road 217		United States	
6				_
by Funeral	Armed Forcas? 1 Nevar Marriad 2 Married 1 Nevar Marriad 2 Married 1 Nevar Marriad 2 Married 1 Nevar Marriad 2 No 1952 1 Yas, Specification of the second of the secon	nt of Hispanic Origin? (Specify Ya y Cuban, Maxicen, Puarto Rican, a No Specify:	Black, Whita, atc. Specify: White	
33		Occupation	16b. Kind of Businass/Industry	
To Be Completed	(Specify only highast grada completed) (Give kind of work life. DO NOT usa	Occupation dona during most of working ratired)		
POC	12 - Building En	gineer	US Gov't	
Be	17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nama (First,	Middla, Maidan Surnama)	
5	John Paul Manyette	Catherine G	wendolyn Catalino	
177	19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa	Number, City or Town, Stata, Zip Code)	
		es Road, Mt. Ai	ry, MD 21771	
	20a. Method of Disposition 1 △ Burlal 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) 20b. Placa of Disposition (Name cematary, cramatory or other cematary) or other cematary.	er placa)	20c. Location - City or Town, Stata 198 Owings Mill, Marylan	d
any injury		Address of Facility r Funeral Home dgeville Blud., of dylng, such as cardiac or raspir	Mt. Airy, MD 21771 Tatory arrest, Approximate Interval Between Onsat and Deeth	
al er	Immediata Cause (Final disaasa or condition resulting in daath) Due to (or as a consequence of):	shot hand	of Head	
Examiner	Sequentially list conditions. Dua to (or es a consequance of):			
edical Examir	if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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ysicia	Part II. Other significant conditions contributing to death but not resulting in the underlying car	usa givan in Part I. 23	Bb. Dtd tobacco use contribute to the cause of dea	th'
d by Physician/M			1 Yes 20 No 3 Probably 4 Unknown	DW
pege 2 should by		24	a. Was an autopsy performed? 24b. Wara autopsy finding available prior to completion of ceusa of daeth?	S
Com			Yas 2 No 1 Yas 2 No	
Be	25. Was cesa rafarred to madical	26. Placa of Death (Chec	<i>(</i>)	
0	axeminer? YSZ Yas 2 □ No Hospital: 1 □ Inpatiant 2 □ ER/Outpatient 3 □ DOA	Othar: —	☐ Residence 6 ☐ Othar (Specify)	
n: To Be	27. Mannar of Deeth 28a Days of Injury 28b. Tima of 28	c. Injury at Work? 28d. De	escribe how injury occurred	
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led in by the funera Certification:	Suicida 4 Homlcida 6 Could not be datarminad 28a. Place of Injury - At homa, farm, straat, factory, building, atc. (Specify)		cation (Street and Number or Rural Route Number, y or Town, State)	1
completely filled in by the fune Medical Certification	29a. Curtifier 1 Cartifying Phyaician: To the best of my knowledga, daath occurrad el company and company and mannar stated. 29a. Curtifier 1 Cartifying Phyaician: To the best of my knowledga, daath occurrad el company and mannar stated.	the tima, data and placa, and due n my opinion, death occurred at th	e to the causa(s) and mannar as stated. a tima, data and place, and dua to tha ceusa(s)	
E Z	29b. Signature and title of certifier 29c.	Licansa number	29d. Data signed (Month, Day, Year)	

OCME

SEPTEMBER 5, 1998

30. Name and addrass of person, who completed cause of death (Itam 23a) (Type, Print)

The Row Witt, 1911 Penn Street, Baltimore, Maryland 21201

State Registrar

868, 94, 31

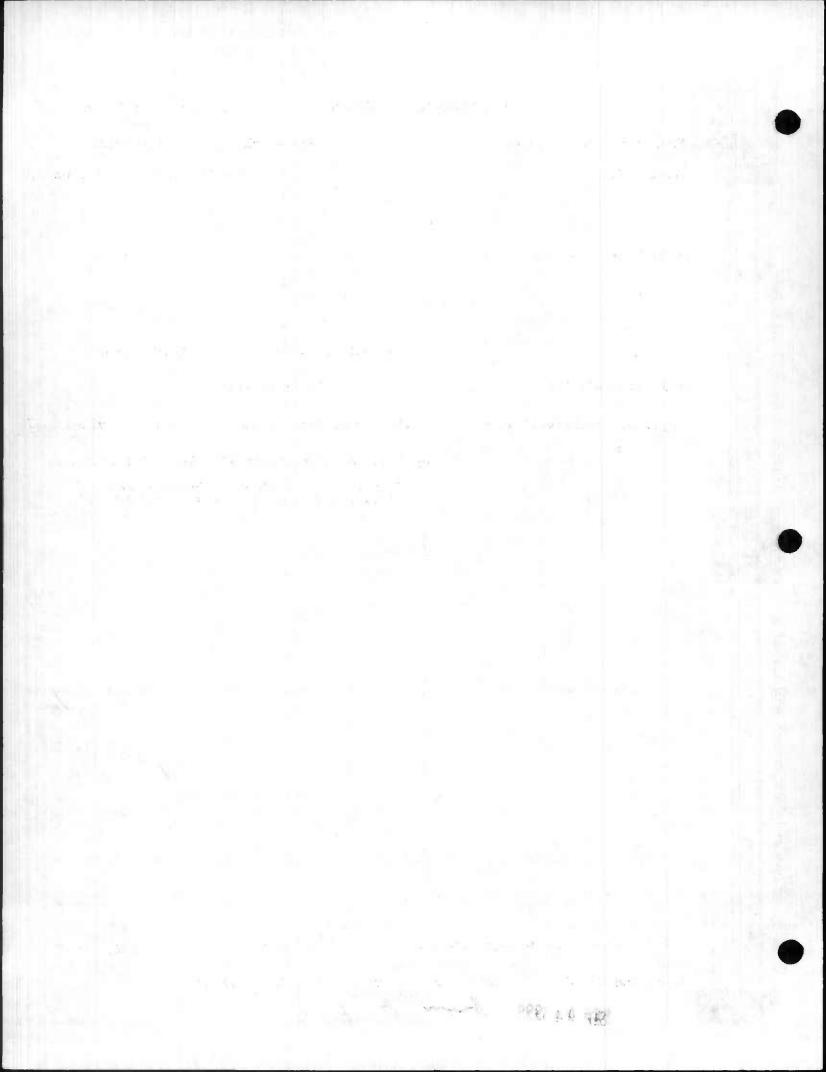
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

olelen		. Decedent's Name (First, Middle, Last,)	7	tificate o		2. Date of Deat			Time of Death
sician edical	_		Lorna M	lae M	JLLINEAU		Septembe	r 2, 19	998 7	:15 P.M
miner	4	a. Facility Neme (If not institution, give Lorine Nu	street end number) rsing Home			4b. City, Town, or Columb		4c. County	_	
ral tor		. Social Security Number 6. Sec 225–32–3392		rs. last birthday) Yrs.	If Under 1 Year Months Day		8. Date of Birth (Month, Day, Oct. 9,	Ý 913	9. Birthplace Country) Virg	(State or Foreig
ompleted by Funeral Director	1	Usual Residence of Decedent Oa. State 10b. County Maryland Howal		City, Town or Lo	cation Columbia	a				inside City Limit
Direct	1	0e. Street and Number 6513 Quie	t Hours, Apt	. T-2	10f. Zip Code	21045	10	0g. Citizen of V	What Country?	
by Funeral Director			12. Was Decedent Ever In Armed Forcas? 1 ☐ Yes. 2 ☐ Who If Yes, Give Year or Dates:	13. V	Vas Decedent of Yes, specify Cu	f Hispanic Origin? (Suban, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		e - American II k, White, etc.	
Completed		15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e com <i>pleted)</i> College (1-4or 5+)	(Give	ent's Usuai Occ kind of work dor DO NOT use reti naker	ne during most of wo	rking	16b. Kind of Bu	isiness/Industr	у
B	1	7. Father's Name (First, Middle, Last) Walter Ro	ose	nome	naker		me (First, Middle, A	Aaiden Surnam		
To		19a. Informant's Name/Relationship (Ty Earl Rose,			-	et and Number or Ri				
	2	0a. Method of Disposition 1 Burlai 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Removel from State Mt	o. Pleca of Dispos cemetery crem	sition (Name of natory or other p	ery Ser	Date 5, 19	20c. Location - 98 Fre		
once	2	21. Signature of Funeral Service Licanson		21 0 022	Name and Add Keeney	dress of Facility & Basford St Church	Funeral	Home Frederi	ck. MD	21701
n	1	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	icetions that caused the di ne cause on each line.	Do not ente	er the mode of d	lying, such as cardia	or respiretory erre	est,	inte	proximete erval Between set and Death
al er	r	mmediate Cause (Final disease or condition esulting in death)	METASTI Due to	aric R o (or as a conseq		(666	CANLER		2	mon LIAS
Examiner	1 5	Sequentially list conditions,	Due to	o (or as a conseq	uenca of):					
edical	ti	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	Due to	(or as e consequ	uence of):					
Physician/M	P	art II. Other significant conditions con		esulting in the un	iderlying cause	given in Part I	23b. Did to	bacco usa cor	atribute to the	cause of death
by Phys			and the document of the control of t	ooding in the di	out on the second	grow ar t care i.				y 48 Unknow
Completed b							24e. Wes en		eveileb	autopsy findings le prior to ation of cause h?
							1 □ Y€	s 2 No	1□Ye	s 2□No
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on: To		7. Menner of Death 1 ☑ Natural 5 ☐ Pending	1 ☐ Inpatient 2 28e. Date of Injury (Month, Day Year)	28b. Time of injury	28c. tn	jury at /ork?	dome 5 ☐ Reside 28d. Describe ho			
Cat		2 Accident Investigation 3 Suicide Could not be determined	28e. Placa of Injury - A building, etc. (Spe	t home, farm, streetly)		□Yes 2□No ce	28f. Location (St. City or Town	reet and Numb n, State)	er or Rural Ro	ute Number,
entit	-	9a. Certifier 1 Certifying Phys	piclan: To the best of my k ner: On the basis of exam	nowledge, death ination and/or inv	occurred at the estigation, in my	time, date and place y opinion, death occu	a, and due to the ce arred at the time, de	euse(s) and me ate and placa,	nner as stated and due to the	1. cause(s)
edical Certification:	1	(Check only 2 Medical Examinations)	and manner stated.							
Medical Certifical		(Check only 2 Medical Examin	and manner stated.	lm		onse number		9d. Date signed	1 .	998

State of Maryland / Department of Health and Mental Hygiene

		1 Decedeste News (Fire Mars 1	-41		Certific	ale of	Deam	lan: .	Reg. No.		
hysicia	an	Decedent's Nama (First, Middle, Last	2224111111					2. Data of De Month	ath Day	Year	3. Time of Deat
/Medic			Hugh Lar	caster	McWil			Septemi			6:45pm
xamin	er	4a. Facility Nama (If not institution, give	a straat and number)				4b. City, Town, or	Location of Deat	4c. Co	ounty of Death	
		Frederick Memoria		// t /	44. 1 (f.11m	dar 1 Yaar	Frederi			rederi	
ineral ector		5. Social Sacurity Number 6. S 578-24-2223 Usual Residence of Decedent	ex /. Age ŽiM 2□ F	(In yrs. last bir	Yrs. Month		Hours Mir		th ly, <i>Year</i>) , 192	9. Birth Cou	pplece (State or Formintry) hington D
A ti		10a. State 10b. County		10c. City, Town	n or Location					T	10d. Inside City Lin
Ded	tor	Maryland Frederi	ck	Monroy	ria						1 ☐ Yas 2 📆
tour l	Director	10e. Street and Number		1101120		Zip Code			10g. Citiza	n of What Cou	intry?
ST P		11795 Thomas Sprin	gs Drive		1 1	21770)		Unite	ed Stat	es
edical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Naver Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant E- Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1				fispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		Raca - Amer Black, White becify:	
ical	ted	15. Decedent's Ed	ucation	16a.	Decedent's U	suai Occup	pation		16b. Kind	of Business/li	
the Medical	Completed	(Specify only highest gra	Ge com <i>pletad)</i> College (1-4or 5+)	life. DO NO	Tuse retired	during most of wo	orking			
200	Con	12			Tele	phone	Service	es	U S	Gove	rnment
matic event,	Be (17. Fathar's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	Maiden Su	mame)	
etic	10	Hugh L. McWilliam	ıs				Ellen M	. Russel	1		
5		19a. Informant's Name/Relationship (7		19b.	Mailing Addr	ess (Street	and Number or F	lu <i>ral Rout</i> e Numb	er, City or T	own, State, Zi	ip Code)
any injury or other traumatic once.		Meyrl R. McWillia 20a. Method of Disposition 1 Burial 2 Scramation 3 Department of Donation 5 Other (Specify	Ramoval from State	20b. Placa of cemeter	Disposition (I y, crematory o	Vame of or other place	ce)	Date	20c. Loca	tion - City or T	
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any la		h ladel 9	1/1/11	1	01in	L. Mo	leswort	h_P. A.	Funera	1 Home	2
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused to	he death. Do r				Damascu		ryland	20872 Approximate
ian		shock, or heart failure. List only	one cause on each line								Interval Between Onsat and Death
ical		Immediate Cause (Final disease or condition	14	npho	ma.					į	1 VEAR
ner		resulting in death)	a	110 101 28 20	onsequance	oft:				I	(/ 6
	ner		V = F / 1	00 10 (01 00 0	onocquanoo	o.,.					
	Examiner	Saquentially list conditions,	b. — D	ue to (or as a c	onsaquance o	of):					
5		Saquentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseasa or injury								i	
201	edicai	that initiated events resulting in deeth) Last	C	ue to (or as a c	onsequance o	of):					
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or us	lan/		d								
ped	Physician/	Part II. Other significant conditions co	ntributing to death but	not resulting in	the underlyin	g cause giv	en in Part I.	23b. Did	tobacco us	e contributa i	to the cause of des
	by Ph							10	Yes 2	No 3□ Pro	obably 4 Unkn
should b	Completed b							24a. Wes	an autopsy	av	Vere autopsy finding vallable prior to
200	D D				3134					/ 01	ompletion of cause f death?
peged	S							10	Yes 201	No 1	☐ Yes 2☐ No
	Be	25. Was case referred to medical axaminar?					26. Place of De	ath (Check only	one)		
	2	1 ☐ Yes 2 No	Hospital: 1 Inpatiant	2□ ER/Out	patient 3		4 🗆 (Autoling)	Homa 5 ☐ Resi			ify)
he funera	Certification:	27. Manne of Death 1 Naturel 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day	(ear) 28b. T	ime of njury M	28c. Injur Wor 1	yat k? Yas 2□No	28d. Dascribe	how Injury o	occurred	
completely filled in by the funeral	Certific	3 Suicida 6 Could not be determined	28e. Placa of Injury building, etc.		m, straat, fact	tory, office		28f. Location (: City or To		lumber or Rur	a <i>i Ro</i> ute Number,
letely til	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Madical Exam	sician: To the best of iner: On the bests of e and manner state	xemination end	death occurre Vor Investigeti	ed et the tin ion, in my o	ne, date and plac pinlon, death occ	e, and due to the urred et the time,	cause(s) an date end pla	d manner as s aca, and due t	stated. to the cause(s)
	Me	29b. Signature and title of cartifier				29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)
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сошрів	2.0	> Kenenta	2	2		DI	11166)		mber 2,	1000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month 1998 Margaret Rebecca August 7:40am 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Frederick Health Care Center Frederick Frederick If Under 1 Year Months Days 5. Social Sacurity Number If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 1 M 2 X F 220-26-2314 Yrs. 82 Maryland Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Frederick Frederick 1X Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 700 East South Street 21701 U.S.A. 14. Race - American Indian, Black, Whita, atc. 12. Was Dacedant Evar in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 🛣 No If Yas, Giva Yaar or Datas: 1 Navar Married 2X Married White 1 Yas 2 XNo 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) BRIGHTWELL Claude KEMP Elsie 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mr. Leo Delibera/Nephew 5711 Harland Street, New Carrollton, MD 20784 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Mt Olivet Cemetery Sep 1, 1998 Frederick, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility Keeney & Basford P.A. Funeral Home weren M00706 106 East Church St, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) 75.E. Dua to (or as a consaquance of) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consaguance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Waa an autopsy performad? 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3□ DOA 27. Mannar of Death 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Natural 2 Accident 5 Panding 1 ☐ Yaa 2 ☐ No Invastigation 6 ☐ Could not be datarmined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

who complated cause of death (Itam 23a) (Type, Print)

32. Registrar's Signatura

300

rriston

1 1998

29d. Data signed (Month, Day, Year)

Box 68760, Division of Vital Records, P.O.

The law requires that the death certificete be executed physician and s tha buriel-transit ed by the attending deteched for use as usa been signed by should be detec Ser certificeta or Attending Physicien: diractor. Aftar thi funarel death. To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completaly filled in by the fu

Physician

/Medical

Examiner

10a Stata

Funeral

Director

28a-f ahow

Director

Funeral

by

Completed

Be

/ is marked other than "netural", or items 23a or 28a-f ahov traumatic event, tra Medical Examiner mant be notified at

Peges 1 and 2 should be filed within 72 hours after nant of Haalth end Mental Hygiene. Int: If Item 27 is marked other than "netural", or ite

permit. Peges 1 and 2 s Department of Health en Important: if Item 27 is: eny Injury or other trau

Physician /Medical

Examiner

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Cartifian

10

29b. Signatura and titla of cartifiar

30. Nama and address of

Baltimore, Maryland 21215-0020

the Maryland

with

State Registrar

100 : 1. 1 7 min 1 .

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedant's Nama (First, Middle	a. Last)		Certii	icate of	Dealli	2. Data of De	Reg. No.	1-0	3. Tima of Death
Physic		Joseph Dennis Ma						Month	Dey	Yaar	
/Medi Examlı		4a. Facility Nema (If not institution)		-	lb. City, Town, o	Septem Location of Deat	ber 4, 19		1:05p.m
LAGIIII	iici	Chestertown Nurs	sing & Rehab				Cheste		Ken		
Funeral Director		5. Social Sacurity Number 237-62-2774 Usual Rasidance of Dacadant		ga (In yrs. last b 76		Undar 1 Year onths Days	If Undar 24 Hr Hours Min	s. 8. Dete of Bir	th	9. Birthpl	ace (Stata or Foreig vewark, DE
yland		10a. Stata 10b. County		10c. City, To	wn or Location	on				10	Od. Insida City Limits
e Mar	Director	Maryland Kent		Kenr	nedyvi.	lle					1 ☐ Yas 2 No
23a or 2	al Dire	10e. Street and Number 28260 Morgnec Ro	oad		1	10f. Zip Coda 216	45		10g. Citizan of W U.S.A		try?
in 72 hours effer death with the Maryland "natural", or items 23s or 28s-f show fedical Exprince rives to notified at	by Funeral	11. Merital Status 1 □ Navar Married 2∑ Marr 3 □ Widowad 4 □ Divorcad	12. Was Decedant Armed Forces' ied 1 ☐ Yas 2 ☑ If Yas, Give Year or Datas:	?		Decedent of H is, specify Cube Yas 2XNo	ispanic Origin? (n, Mexican, Pua Specify:	Spacify Yes or No rto Rican, etc.)		- Amarica c, White, a Whi	itc.
within ane. than	Completed	15. Decaden (Specify only highes Elamentary/Secondary (0-12)	's Education st grade completed) Collaga (1-4or	5+)	(Giva kind lifa. DO l	s Usuai Occup of work done o NOT usa ratired /Selfem	during most of w	orking	16b. Kind of Bu		ustry
Hyge H	BeC	17. Fathar's Nama (First, Middla,	Last)		CIMCL	/ DCLICIII		ame (First, Middla	, Maidan Sumeme	-0.	
	To B	Joseph Francis M	Maloney				Ellen	G. McCl	oskey		
S sh end is m		19a. Informant's Name/Ratations							er, City or Town, S		Code)
Haali Haali Brm 2		Alice M. Maloney 20a. Mathod of Disposition	7/W1Ie		28260] of Dispositio		Road, 1		ille, MD		
		1 Buriel 2 □ Cramation		camat	ary, cremato	ry or othar plac	a)	Data			
		4 Donation 5 Other (Sp 21. Signature of Fuperal Service I	•	Chest		metery ama and Addres	es of Encilib	9/9/98	Chestertow	n, Mai	ryland
permit. Departn Imports any inje		23a. Part1. Enter the disease or shock, or heart failura List	/ Welfen	leis)	Fello 130 S	ows, Helf Speer Roa	enbein & d. Cheste	rtown. Mar	eral Home, yland 2162		Approximata
ettending physician and for use es the bunal-trensit	n/Medical Examiner	Immadiate Causa (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immadiate causa. Enter Undertying Cause (Disease or Injury that initiated avants resulting in death) Last	b. Se	Dua to (or as a Dua to (or a) Du	a consaquant	nydroce of): nal ca of):	Filh	ure_			I week
the de	Physician/M	Part II. Other significant conditio	^			lying causa give	an in Part I.		-		the cause of death
sign d be	by	Multint	one do	ment	14,				Yes 2 No an autopsy	24b. Wa	ably 4 Unknow
	Completed	- VZYKIM	ions di	Sers				perfo	ormad?	of d	ilabla prior to applation of causa aath?
hes b											
The law ate hes b page 2 s		25. Was case refarred to medical					26 Piece of De	1 L	Yes 20 No		Yas 20 No
Physician: The law this certificate hes b al director, page 2 s	To Be	25. Was case refarred to medical axaminar? 1	Hospital: 1 Inpatii 28a. Data of Inju (Month, Da	iry 28b.	Tima of Injury	DOA Othi	Nursing		Yes 25 No ona) danca 6 □ Othe how injury occurre	r (Specity	
Attanding Physician: The law death. clor: Atter this certificate hes by the funeral director, page 2 s	Certification: To Be	axaminar? 1	28a. Data of Inju (Month, Da ation of be	y Year) 28b.	Tima of Injury	28c. Injun Work	Nursing	Home 5 ☐ Resi 28d. Dascribe	danca 6 Othe	r (Specify	
Attanding Physician: The law death. clor: Atter this certificate hes by the funeral director, page 2 s	Certification: To Be	axeminar? 1 Yas 2 No 27 Mannar of Daeth Natural 5 Panding Invastig 2 Accidant 3 Suicida 6 Could n datarmi 29a. Cartifiar Certifying	28a. Place of Injuitding, at	ury - At homa, fc. (Spacify) of my knowledgf axamination a	Tima of Injury	28c. Injury Work 1 1 5	Nursing at at a No	28d. Dascribe 28f. Location (City or Total	danca 6 Othe how injury occurre	r (Specify, ad	Route Number,
ttending Physician: The law death. 30r: After this certificate hes by the funeral director, page 2 s	To Be	axaminar? Yas 2	28a. Data of Inju (Month, Da 28a. Place of Inju (Month, Da 28a. Place of Inju buitding, at	ury - At homa, fc. (Spacify) of my knowledgf axamination a	Tima of Injury	28c. Injury Work 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Art Nursing Yas 2 No a, data and piace pinion, daath occurrence number	And dua to tha time,	danca 6 Othe how injury occurre	r (Specify, ad a ror Rural anar as stand dua to	Routa Number, sted. the cause(s)
Attanding Physician: The law death. clor: Atter this certificate hes by the funeral director, page 2 s	edical Certification: To Be	axaminar? 1	28a. Data of Injuition of be nad 28a. Place of Injuitiding, at put of the part of the put of the part	ury - At home, for c. (Spacify) of my knowledge faxamination a stad.	Time of Injury street, street, street, occurrence of Injury street, occurrence occurrenc	28c. Injury Work 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	er set of Nursing vas 2 No	And dua to tha time,	danca 6 Othe how injury occurre Straat and Numba wn, Stata) causa(s) and mar data and place, at 29d. Data signed	r (Specify, ad a ror Rural anar as stand dua to	Route Number, sted. the cause(s)

SEP 0 8 1938 See 5

WILLIAM NEFF State of Maryland / Departme AMEND ITEM: #27 28D PER MEO G782 4-13-0 Certifica

nt of Health and Mer	ntal Hygiene	- 0		n	14	[
te of Death	Dog No.	*1	4	U	0	

1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Year **Physician** William Robert Neff AUGUST 31, 1998 1015 PM /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** UPPER POTOMAC WATER COMMISSION WESTERNPORT Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days DOM 20 F 46 Yrs 212-54-7906 Aug. 26, 1952 West Virginia Director Usuei Residenca of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 77 is marked other than "natural", or itsms 23a or 28a-f show traumetic event, tra Modical Evantiner must be notified at Mes 2□No Md Allegany Director Westernport 10f. Zip Code 10a. Citizen of Whet Country? 10e. Street and Number 209 Ross Street 21562 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Raca - American Indien 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marifal Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 200 No If Yes, Give Year or Detes: 1 Never Married XX Married 1 ☐ Yes 2 ☐ No Specify: Specify: White altimore, Maryland 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Upper Potomac al Hygiena. Elementary/Secondary (0-12) 12 College (1-4or 5+) River Commission Superintendent permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Important: If item 27 is merked other any injury or other traumest. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be William Neff, Jr. Betty Warnick 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Cynthia Neff / Wife 209 Ross St. Westernport, MD 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Philos Cemetery 9/4/98 4 ☐ Donation 5 ☐ Other (Specify) Westernport, MD 21. Signeture of Funeral Service Cicensee 22. Name and Address of Facility 111 Church Street Boal Funeral Home Westernport, MD 21562 23e. Part1. Enter the disease, of complications that ceused the dea 1. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Drowning /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as sonsequence of): Examiner bunial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): and physician Physician/Medical the Due to (or as a consequence of) USB 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. O signed by t d be detact 2/K No 1 Yes 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings available prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed? peeu page 2 12 Yes 1 Yes 2□ No 2 No certificata Division of Vital Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX Yes 2□ No 2 this funeral 27. Manner of Death Date of Injury (Yonth, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 5 Pending Investigation subject drowned. 1 Naturel 8-31-99 10:15 a M 15 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) aftar death. Director: Aft 2 No 2 Accident Cocation (Street and Number of Pural Poute Number City or Town, State) Ugger formac Wester Comman Allegany, Sul 6 X Could not be determined 0 Seuicide 28f 4 Homicide treatment plant

Allegan

To the best of my knowledge, death occurred at the time, date end place, and due to the course(s) and manner as stated.

The destination of the best of my knowledge, death occurred at the time, date end place, and due to the course(s) and manner as stated.

The destination of the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 5 24 hours e Funeral Hospital Medical 29a. Certifier (Check only one) To the To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME SEPTEMBER 1, 1998

State Registrar

Dennis Chute M.D 31. Dete filed (Month, Day, Yeer)

SEP 1 0 1998

32. Registrar's Signature

30. Name and eddress of purpose who completed ceuse of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

2021 1

BRANDON OPOZOO

State of Maryland / Department of Health and Mental Hygiene []

MATAPON OFFICE	,		Oldio Ol	indi yidild /	Dopai
TEMS: #23 PART I	. 27 PER	MEO G764	10-7-98	WR.	Certi

Certificate of Death

If Under 1 Year

3. Time of Death

1004AM

10d. Inside City Limits 1 Ves 2 □ No

	Physician /Medical Examiner
_	

1. Decedent's Name (First, Middle, Last)

4a Fecility Name (If not institution, give street and number)

DAVID OROZCO 2. Date of Death Day Month

SEPTEMBER 03, 1998

Funeral

SHADY GROVE ADVENTIST HOSPITAL E.R. 5. Social Security Number 7. Age (In yrs. last birthday)

1₩ M 2□ F

ROCKVILLE

4b. City, Town, or Location of Deeth

4c. County of Death MONTGOMERY COUNTY

Year

Director

10a. State 10b. County Maryland Montgomery

BRANDON

Hours Min. July 6, Months 10c. City, Town or Location

9. Birthplace (Stete or Foreign Country) Maryland

Directo 10e. Street and Number Funeral p

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant, my Modical Examiner must be notified. Completed Be

2

Germantown 19505 White Saddle Drive

10f. Zip Code 20874 10g. Citizen of What Country?

11 Marital Status

213 53 5436

Usual Residence of Decedent

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No !! Yes, Give Year or Dates:

 Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Rece - American Indien, Black, White, etc. White Specify:

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) N/A

22. Name and Address of Facility

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Malden Sumeme)

Gerardo Orozco

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)

Deborah Weissman

Gerardo Orozco/father 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, cremetory or other place)

19505 White Saddle Dr Germantown, MD 20c. Location - City or Town, State

Approximete Intervel Between Onset and Death

Burial 2 Cremation 3 🖂 4 Donation 5 Other 50

Parklawn Memorial Park

9/6/98

Rockville, Maryland

21. Signature of Funeral Sax

Danzansky Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, Maryland 20852

Physician /Medical Examiner

physician and s the burial-transit

as USB

signed by the a

page 2 has

funeral director,

filled in by

cartificate

this

After

after death.

24 hours 8 Hospital

To the

within 24 hor To the Fune completaly fi

or Attending Physician:

by

Completed

Be

10

Certification:

edical

the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical

Immediate Cause (Final

disease or condition resulting in death)

SUDDEN INFANT DEATH SYNDROME

Due to (or as a consequence ot):

23a Part 1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heelt failure. List only one cause on each line.

Due to (or as a consequence ot):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b.	Did	tobacc	o use	con	tribute	to	the	caus	8e C	of de	ath?	,
	1 🗆	Yes	2 10 N	0	3 🗆 Pı	rob	ably	4		Unk	now	n

24a. Was en eutopsy performed?

24b. Were autopsy tindings available prior to completion of cause of death?

1 Yes 2 □ No

12 Yes 2 No

25. Was cese referred to medical examiner? 1⊠Yes 2□ No 27. Menner of Deeth

31. Date tiled (Month, Day, Year)

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA investigation

28e. Dete of Injury (Month, Dey Year) UNKNOWN

28b. Time of Injury UNKNOWN

MD

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

UNKNOWN

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

29a. Certifier (Check only one)

1 Naturel

2 Accident

3 Sulcide

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) UNKNOWN

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signeture end title of certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number

26. Plece of Death (Check only one)

O.C.M.E.

SEPTEMBER 04, 1998

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print) 5. Radentz, Stephen

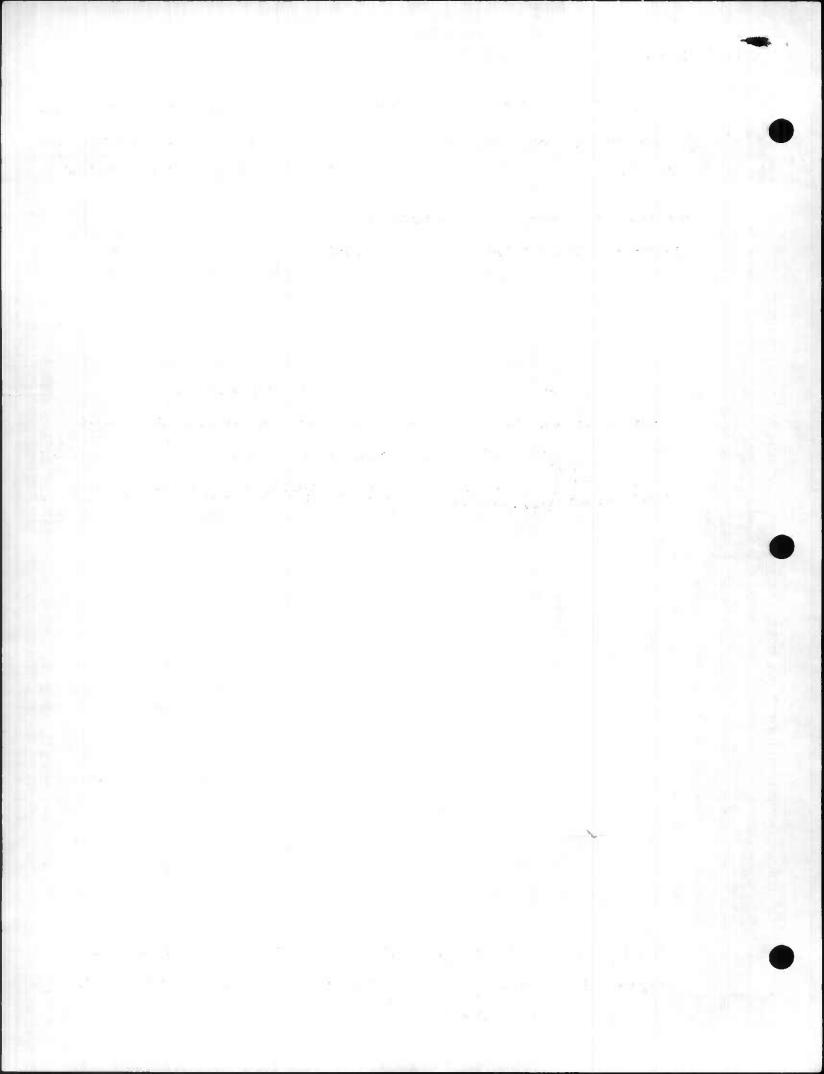
6 Could not be determined

111 Penn Street, Baltimore, Maryland 21201

State Registrar

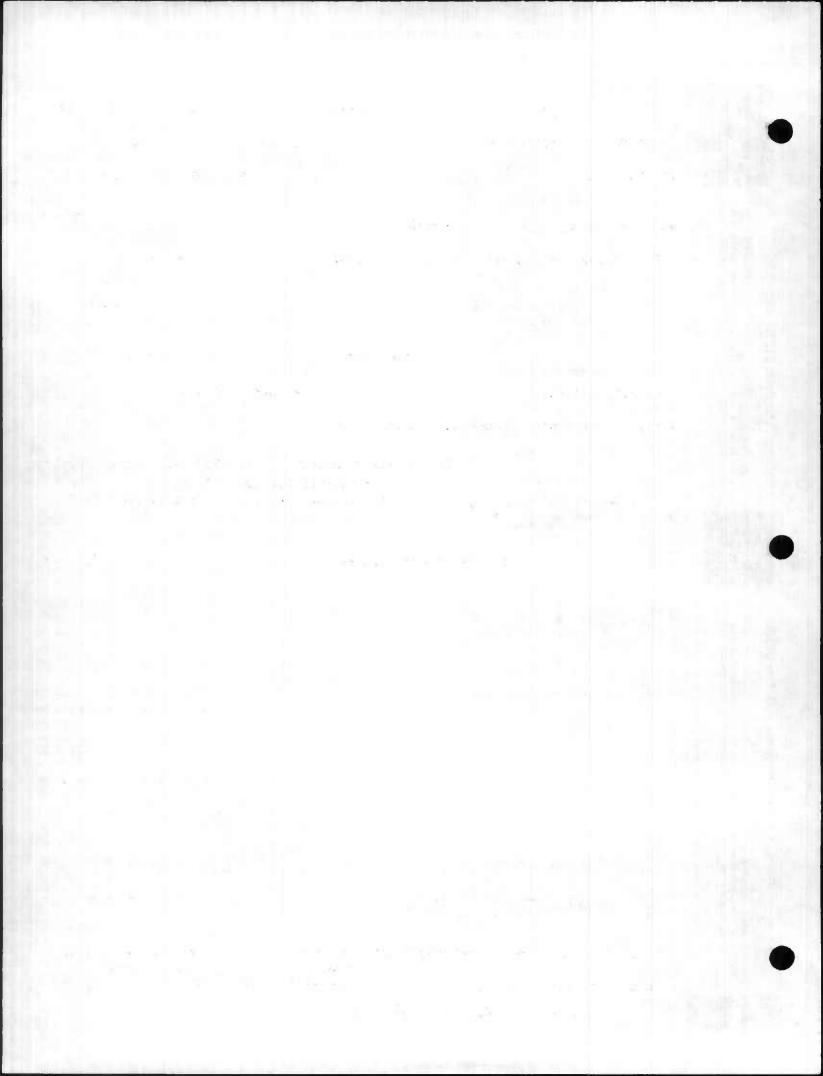
SEP 0 8 1998

32. Registrar's Signeture



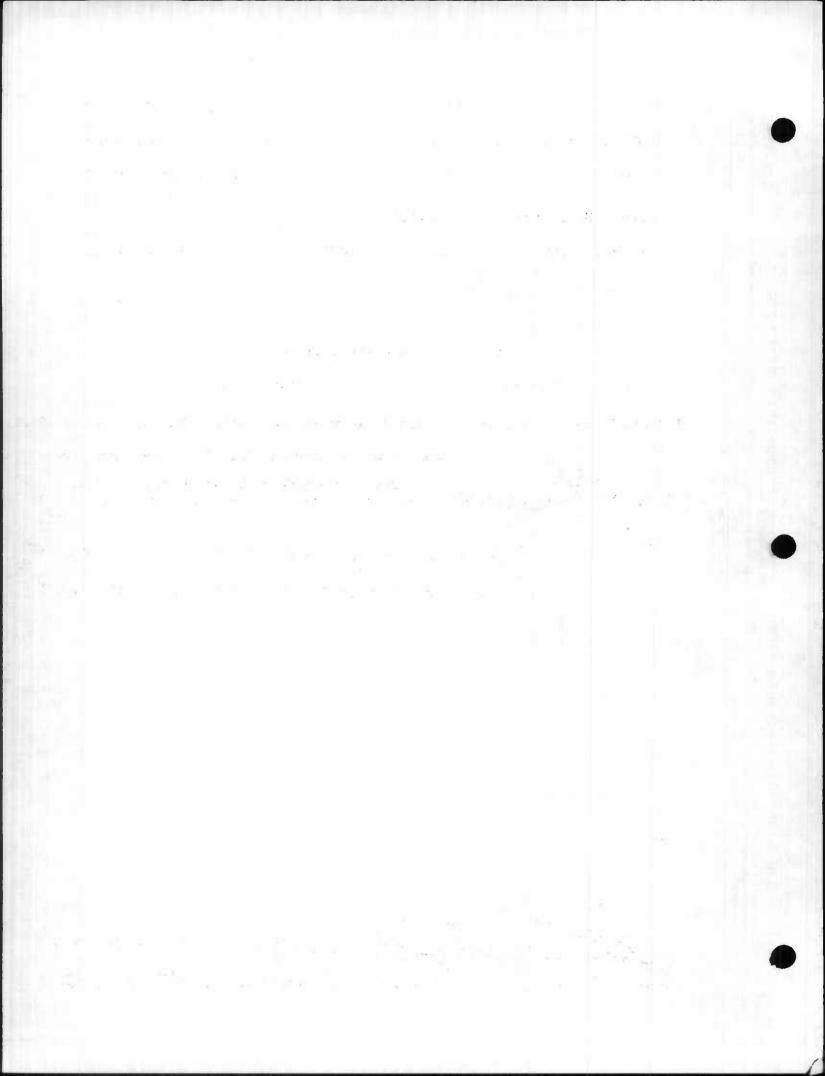
State of Maryland / Department of Health and Mental Hygiene

			Certific	cate of	Death		Reg. No.	4.9067
Physician /Medical	Decedent's Neme (First, Middle, Last Sophi	e P.	Pet	erson		2. Dete of Dec Month Septemb	Dey	Year 998 2:50 PM
Examiner	4e Fecility Neme (If not institution, give 8324 Cottage Hil.					Location of Deeth		
Funeral Director	5. Sociel Security Number 6. Se 101-03-5682			Under 1 Year nths Deys	Gaither: If Under 24 Hr Hours Mir	s. 8. Dete of Birt	th y, Year)	gomery 9. Birthplece (State or Foreign Country) New York
ayland ahow	Usuel Residence of Decedent 10e. Stete 10b. County	10c.	City, Town or Location	n				10d. Inside City Limits
vith the Me or 28a-fs	Maryland Montgome	ry G	aithersbu				10- Chi11	1 Yes 2 No
th with the sale or 3 and Oir	10e. Street end Number 8324 Cottage Hil	l Court		7. Zip Code 20877			10g. Citizen of V	
72 hours effer death with the Meryland "natural", or terms 23s or 28s-f show correl Exercities must be notified at letted by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		Decedent of to , specify Cub 'es 2 No		Specify Yes or No rto Rican, etc.)	Specify	e - American Indien, ck, White, etc. White
natural natural eted	15. Decedent's Edu (Specify only highest gred		16e. Decedent's	of work done	during most of wi	orkina	16b. Kind of B	usiness/Industry
withly with the number of the	Elementery/Secondery (0-12)	College (1-4or 5+)	Homemak	OT use retire	d)		Oran II	lomo
	12 17. Fether's Name (First, Middle, Last)	2 10047	пошешак	ter	18. Mother's Ne	eme (First, Middle,	Own H	
0 5 D 9 m	Anthony Plonsk	i			Anton	ia Oban	ra	
d 2 should the and Men 7 is market trsumatic	19e. Informent's Neme/Reletionship (T)	rpe, Print)	19b. Melling Ad	dress (Street	end Number or F	Rural Route Numb	er, City or Town,	State, Zip Code)
	Janine P. Marchane 20e. Method of Disposition) Same a			Dete	20c Location	City or Town, Stete
	1 Burlel 2 Cremetion 3 F 4 Donetion 5 Other (Specify)	Removel from Stete	cemetery, cremetor	y or other ple				
pemit. Peges Department of Important: If i any injury or once.	21. Signeture of Funerel Service Licans		hesapeake			9-5-98 ces, P.		lle, Maryland
Depa Impo any ii	> Clen X.	Kano				ices, r. Silver Sp		D 20910
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	e. <u>Metastati</u> Due to	c Lung Can					Onset end Deeth
tificate be executed to physician end es the buriel-transit	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initleted events resulting In deeth) Lest	c	(or es e consequence					
es that the death certified by the ettending be deteched for use by Physician/M		d						
the deay the eached f	Pert II. Other significant conditions con	ntributing to death but not r	esulting in the underly	ying cause gi	ven in Pert I.	23b. Dld	tobacco use co	ntribute to the causa of death
that the ped by a dete						1/2	Yes 2□ No	3 Probably 4 Unknow
requir seen s hould							en eutopsy ormed?	24b. Were eutopsy findings evailable prior to completion of cause of deeth?
F 66 ()		V 187 19				10	Yes 2 No	1 ☐ Yes XIX No
Physician: The law this carificete has braid director, page 2 strain director, page 3 strain director,	25. Wes case referred to medical exeminer?	Hospitel:		Oti Oti	har	eth (Check only o		
this alo	1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Inju Wo	4 LI Muising	Home 5 N Residence 28d. Describe	denca 6 LIOth	
To the Hospital or Attending P within 24 hours efter death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Sulcide 6 Could not be 4 Homicide determined	28e. Pleca of Injury - At building, etc. (Spe	home, farm, street, f	ectory, office		281. Location (City or Tox	Street and Numb wn, State)	ber or Rural Route Number,
n 24 hours n 24 hours he Funer pletely fill	29e. Certifier 1X Certifying Physical Check only 2 Medical Exami	sicisn: To the best of my k ner: On the basis of examl end menner stated.	nowledge, deeth occu netion end/or investig	urred et the ti pation, In my	me, dete end plea opinion, deeth occ	e, end due to the curred et the time,	ceuse(s) end modate end plece,	enner es stated. and due to the ceuse(s)
within To the compl	29b. Signature end title of certifier			29c. Licens	se number		29d. Date signe	d (Month, Dey, Year)
4	1 Money	a 803	AND YOU	D430	083		Septembe	er 4, 1998
	30. Neme and eddress of person who con George A. Soto:		tem 23e) (Type, Print)			Center MD 2085		
State Registrar	31. Date filed (Month, Day, Year) SFD 0 8 199	32. Registrer's Sig	nature	long	,			



State of Maryland / Department of Health and Mental Hygiene

Physician /Medical	1	. Decedent's Neme (First, Middle, Las		v Tom				2. Dete of De Month	Reg. No. ath Dey	Vaca	Time of Death
	L	Naomi		Price				-	, 1998	/	7:30 P
Examiner	4	e Fecility Neme (If not institution, give	streat end number)				b. City, Town, or	Location of Deeth	4c. County	of Deeth	
		11409 Commonwea					Rockvill			gomery	
Funeral Director		Social Sacurity Number 107-20-7933 Sual Rasidence of Decedent	ox 7. Ag □ M 2⊠ F XX	e (In yrs. lest b		If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De July 24	th y, Year) 1928	9. Birthplace Country) New Yo	(Stete or Foreign ork
ž u	1	0e. State 10b. County		10c. City, To	wn or Loca	ntion				10d. li	nside City Limits
fled to	1	Maryland Montgo	mery	Roc	kvill	le				1	☐ Yes 2X No
tiems 23s or 23s-f showner must be notified at uneral Director		0e. Street and Number 11409 Commonwea	1th Place	#103		10f. Zip Code 20852			10g. Citizen of V United	Thet Country?	
by F		1. Meritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 H Yes, Give Yeer or Detes:			es Decedent of H res, specify Cubi	lispenic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	- 14. Race Blee Specify	- American Ir k, White, etc. White	
ygians, ner than "nature It, the Medical E Completed		15. Decedent's Ed (Specify only highest grad	ucation de completed)	16	e. Deceder	nt's Usuel Occup	ation during most of wo	rking	16b. Kind of Bu	siness/Industr	/
and a		Eiementary/Secondary (0-12)	College (1-4or	5+)		o <i>NOT</i> use retired istered			Medic	n 1	
		7. Fether's Neme (First, Middle, Last)	4		Regi	Istereu		me (First, Middle			
ever Be		George Michael	Dolin					Palter			
marke		19a. Informant's Neme/Raletionship (7		15	b. Meiling	Addrass (Street	end Number or Ri	ural Routa Numb	er, City or Town,	Stata, Zip Coo	(e)
27 is			(Daughter								nd 20910
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0 0	P	Pert II. Other significant conditions co		ut not rasuiting	In the und	derlylng cause giv	ven in Part I.		tobacco uaa co Yes 2□ No	ntribute to the	1/
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 2, 1998 1350 WILLIAM ELDRIDGE PRICE 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) BETHESDA MONTGOMERY SUBURBAN HOSPITAL 8. Dete of Birth (Month, Day, Yeer) If Under 1 Year 6. Sex 10 M 2□ F If Under 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Months Deys Hours Min. Yrs. 1923 NORTH CAROLINA 74 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo ROCKVILLE MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code UNITED STATES 1913 VALLEY STREAM DRIVE 20851 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian Black, White, etc. Amed Folces: 1X Yes 2 □ No If Yes, Give Year or Deles: WWII 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) FEDERAL GOVERNMENT ELECTRONIC TECHNICIAN 18. Mother's Neme (First, Middle, Maiden Sumame) MAMIE ESTELLE BEASLEY WILLIAM ERNEST PRICE

12 17. Father's Name (First, Middle, Last)

5. Social Security Number

242-20-0827 Usual Residence of Decedent

10a. State

MARYLAND

11. Maritel Status

10e. Street and Number

Directo

Funeral

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Completed

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Physician

/Medical

Examiner

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19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORA SUE PRICE - WIFE 1913 VALLEY STREAM DRIVE, ROCKVILLE, MARYLAND 20851

20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKLAWN MEMORIAL PARK 9-5-98 ROCKVILLE, MARYLAND

of Funeral Struce Lide 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MD Part I. Enter the disease, of complications that caused by leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth

tmmediate Cause (Final disease or condition resulting in deeth) CARDIOPULMONARY ARREST Due to (or es e consequence of) CEBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last SUBDURAL HEMATOMA Due to (or as e consequence of):

THROMBOCYTOPENIA

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC PROSTATE CANCER

25. Wes case referred to medical exeminer?

1 Yes 2 No 27. Menner of Death 5 Pending 1 X Natural

investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1□ Yes 2□ No

MD 43691

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings evailable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

SEPTEMBER 3, 1998

28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed?

26. Place of Death (Check only one)

1 Yes 2 No

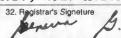
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only 29d. Dete signed (Month, Day, Year) 29b. Signature and title of cogil 29c. License number

Hospital:

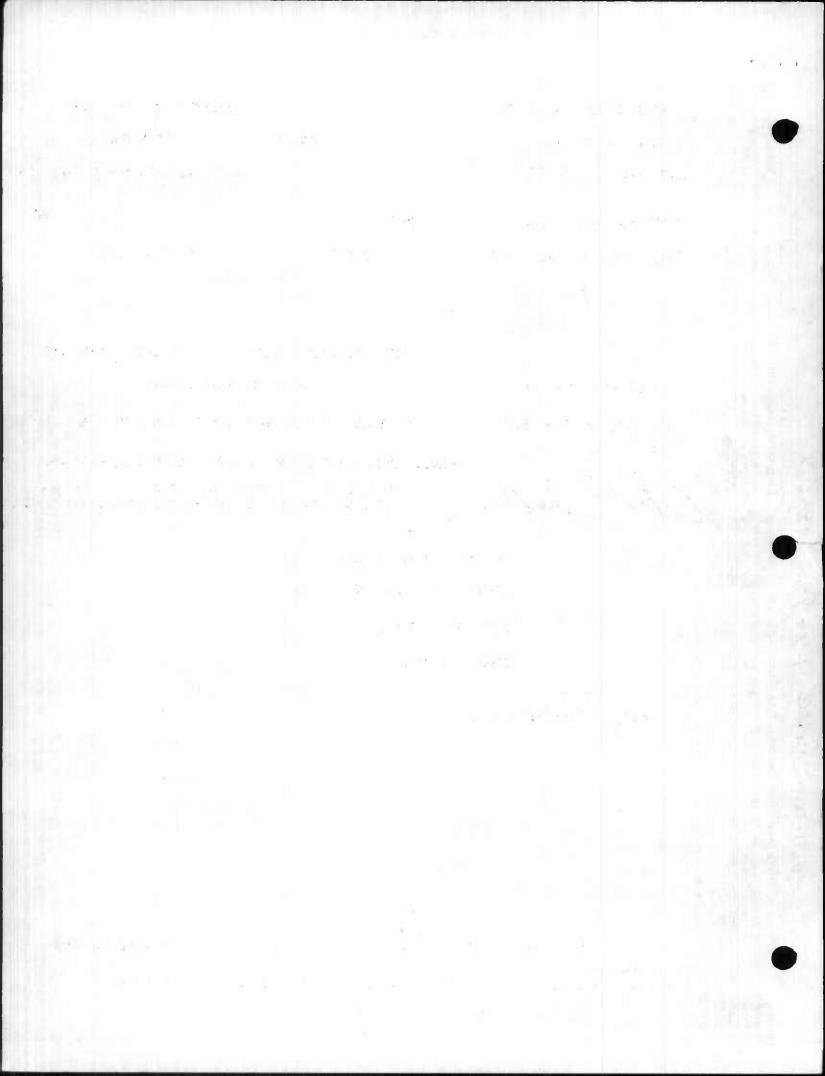
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALEXANDROS POWERS, M.D., 4927 AUBURN AVENUE, BETHESDA, MARYLAND 20814

State Registrar

31. Dete filed (Month, Day, Year) SEP 0 8 1998

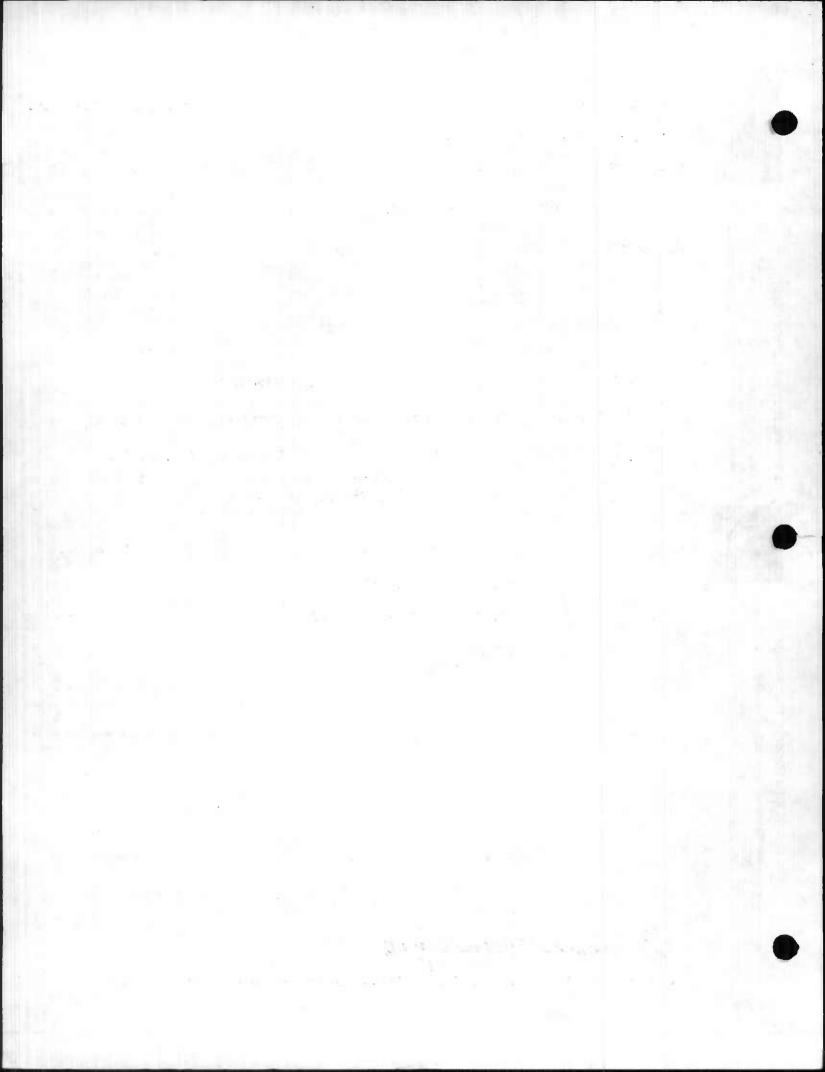






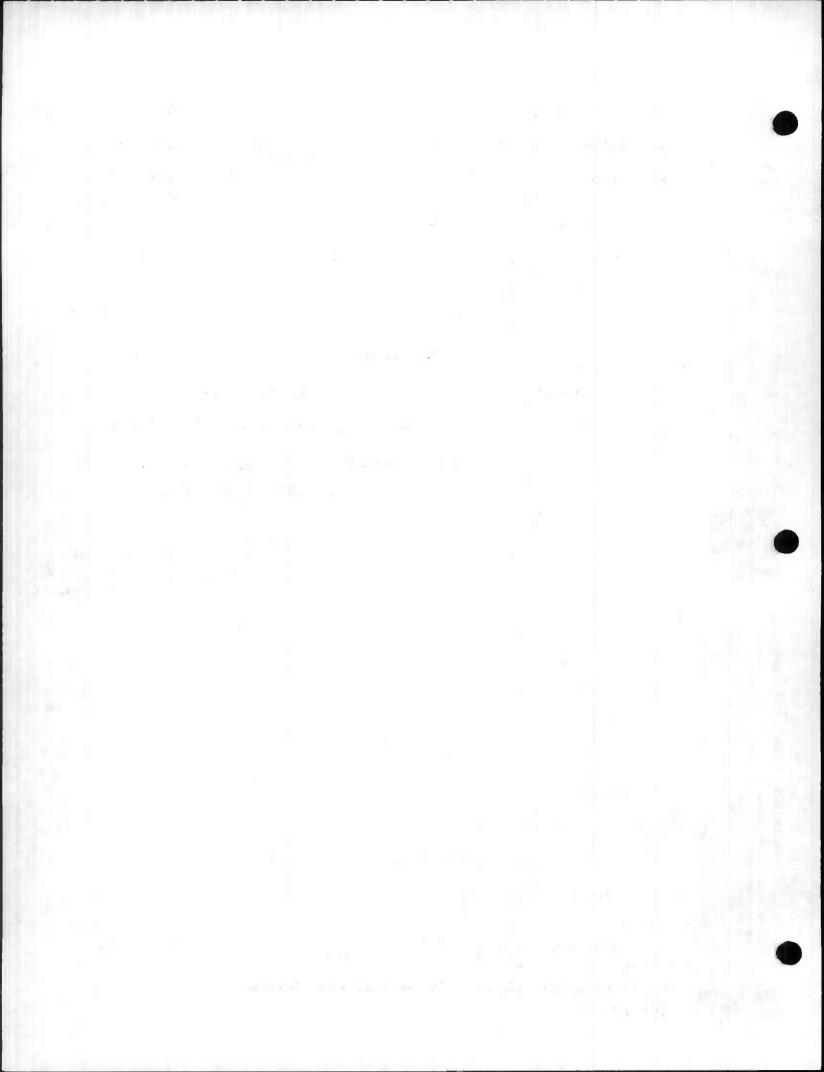
State of Maryland / Department of Health and Mental Hygiene

				11	Certi	ficate of	Death			Reg. No.	1 4	907	0
	Physician	1. Decedent's Name (First, Middle							2. Date of De Month	eth Day	Year	3. Time o	of Death
	/Medical	ADELE ROBY PUGH							AUGUST	23, 19		7:10	P.M.
	Examiner)					cation of Death				
_		5. Social Security Number		ge (In yrs. last t	nirthday)	f Under 1 Year	CHEVY			MONTG		are /State	or Foreign
	Funeral Director	579-32-2768 Usual Residence of Decedent	1□ M 21XF 94	go (117 yrs. aust 2	Yrs.	Nonths Days		Min.	8. Date of Bird (Month, Da JUNE 6	1904	LaPLA	TA, 1	MD
	Menylend of ahow fled	10a. State 10b. County	MERY	10c. City, To		ion				- 100	10	od. Inside (City Limits
	ifer death with the Me r thems 23s or 23s-f a cliner must be northed Funeral Director	10e. Street and Number 8100 CONNECTICU	T AVENUE			10f. Zip Code 20815	12.			10g. Citizen of V	What Count	try?	
020	DY N	3 Widowed 4 □ Divorced	ANNECTICUT AVENUE In Number In New Pugh In M 25 F 94 I	?		s Decedent of es, specify Cul Yes 210 No			ecity Yes or No Rican, etc.)	- 14. Rac Bla Specify	Race - American Indian, Black, White, etc. ecity: WHITE		
21215-0020	led within 72 hours Mglene. her than "natural", nt, ma Medical Erra Completed by	15. Decedent (Specify only highest Elementary/Secondary (0-12)	st grade completed) College (1-4or	5+)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)			tion uring most of working		16b. Kind of B	usiness/Ind	ustry	
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Baltimore,	T T T T T T T T T T T T T T T T T T T			20b. Place cernet	of Disposition	on (Name of ory or other pla ORT CR)	ace)	1	Date	20c. Location	- City or To	wn, Stata	
Baltii	permit. Page Department important: if eny injury or phos.	21. Signature of Furerul Service			370%	SEPH GA	ess of Eacilia	5 SOI	NS, INC	. 5130			AVENUI
	Obveision	23a Part I From the disease, of the disease, o	complications that cause only one cause on each	d the death. Do		, WASHI				rrest,		Approxima Interval Be Onset and	etween
1	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. RESP	IRATORY					E.			ONE D	AY
	ž		ASPTI	ASPIRATION PNEUMONIA								ONE W	rev.
o,	an end riei-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Ь.	Due to (or as a consequence of): MULTIPLE CEREBRAL INFARCTS									ONTHS
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Box	of the death cert d by the attending etached for use Physician/M												LLLINO
	the death cery the attendir sched for use hysician/A	Part II. Other significant condition	ns contributing to death I	out not resulting	in the unde	orlying cause g	iven in Part I	l.	23b. Did	tobacco use co	ntribute to	the cause	of death?
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	yelclen: The lav is certificate has director, page 2 To Be Comp								10	Yes 2 No	10	Yes 2	□No
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n of	E C = '	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Inj	ury 28b	Outpatient Time of Injury	28c. tnju	ork?			dence 6 Oth)	
Division of Vital	a or Attending Physics star death. If Director: After this ad in by the funeral d	3 Suicide 6 Could r	not be 28e. Place of In	jury - At home, lc. (Specify)	farm, street		Yes 2		28f. Location (City or To	Street and Numi vn, State)	ber or Rura	l Route Nu	mber,
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	within 2 To the comple			atou.	,	29c. Licen	se number			29d. Date signe	ed (Month, I	Month, Day, Year)	
	1-31-8	Va Olan	D. Thems bundly up 25441 AUGUST 24								24, 19	98	
	6	30. Name and address of person N. THOMAS CONNA	who completed cause of	death (Item 25)	(Type, Pri		NIIF. N	IW M	IASHTNO	TON DC 3	20016		
	State Registrar	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	4	Some		1119 11	LIDITING	LOIN DU Z	.0010		



State of Maryland / Department of Health and Mental Hygiene

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al .	Margaret L. Pa	ark								Talat	1:45 a.m	
							4b. City, Town, or	Location of Deeth	4c. County	of Deeth		
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era	11. Marital Status 12. Was Decedent E			S. 13	Was Dec			Specify Yas or No				
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by	3 Widowed 4 ☐ Divorced	If Yas, Give Yaar or Datas:			1 🗆 Yas	3€ No	Specify:		Specify		hite	
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Be	17. Father's Nama (First, Middla, Last,)					18. Mother's Na	ma (First, Middla,	Maldan Sumam	(0)		
2	William T. McKe	ee					Albert	a F. (Ho	tt)			
	19e. Informant's Name/Ralationship (Type, Print)		19b. Mei	ling Addre	iss (Stree	t and Number or F	lurai Routa Numbe	er, City or Town,	Stata, Zip	Coda)	
-	Lyle Park-son		1				on Avenue		Land MD	2150	2	
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	4 Donation 5 ☐ Othar (Spacif	y)	Ası	oury C	emet	ery		09/09	Baker,	WV		
	21. Signature of Funeral Service Licer	nee		M 2				_ 7 _ 77	D 7			
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	23a. Part1. Enter the disease, or com shock, or heart failure. List only	pications that caused	tha death	n. Do not ar	ntar tha m	oda of dy	Ing, such as cardie	c or respiratory ar	rrast,		Approximata Intarvai Batween	
			<i>a</i> .	- ,		6.					Onsat and Death	
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xaminer	4a Facility Name (If not institution									
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neral ector	216-22-1997	1⊠ M 2□ F	69	Yrs.	Months Days	Hours	Min. (M	onth, Day, Ye	1928	Country) Maryland
	Usual Residence of Decedent									
notified at	10a. Stata 10b. County	у	10c. City, To	own or Lo	cation					10d. Inside City Limit
ect	Maryland Frede	rick	Thurmo	ont	10f. Zip Code			100	Citizen of V	Vhat Country?
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Funeral Director	11. Marital Status	12. Was Deced	10630 POWELL ROAD 21788 2. Was Decedant Evar in U,S. 13. Was Decedent of Hispanic					USA es or No-	14. Race - Amarican Indian,	
		Armed Formation 1 K Yes 2 If Yes, Give	2 No		Yes, specify Cub ☐ Yas 2 No		, Puerto Hican,	etc.)		k, White, etc.
d by	3 ☐ Widowed 4 ☐ Divorce	d Year or Da	tas: 1932						Specify	White
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a du	Elementary/Secondary (0-12)	College (1-	40r 5+)					7.7	C Co	vernment
S	12 17. Father's Neme (First, Middle	, Last)	5	птрр.	ing Super		r's Neme (First			
To Be	Alton Parker F	Powe 11				Marie	Cather	rine Lo	hr	
-	19a. Informant's Name/Relation		1	9b. Mailin	g Address (Street				The state of the s	State, Zip Code)
	Rose Marie Pow	vell, wife			Powell	Road,	Thurmo	ont, Ma	rylan	d 21788
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation	2 Demoved from S	came	of Dispo	sition (Neme of netory or othar pla	ica)	Dat	e 200	. Location -	City or Town, Stata
	4 Donation 5 Other (Memoria					ck, Maryland
ouce.	21. Signature of Funeral Service	License		22	. Nama and Addre	ess of Facilit	y Staufi	er Fur	neral	Home
ă	Lyan	Tu &	Deice	10	521 Oposs	sumtow	m Pike	Frede	rick,	MD 21702
	23a. Part1. Enter the disease, of shock, or hear failure. Lis	or complications that ca t only one cause on ea	used the death. D	o not ente	er the mode of dyl	ng, such as	cardiac or resp	iratory arrest,		Approximate Interval Between
	Immediate Course (Final		Diag		^					Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a	PVIC	elv	nonce	2				
چ 🖥			Due to (or as	a conseq	uenca of):	c1 .	1.	DI2	MA. 41	Dra years
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequenca of): Chunic Obstructi- ePul minery Disease Sequentially list conditions, Due to (or as a consequenca of):									
EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury									
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Me		d								
cian										
by Physician/Me	Part II. Other significant condit	lons contributing to dea	ath but not resulting	g in the ur	nderlylng cause gi	ven in Part I	0	3b. Did toba	_	ntribute to the cause of dear
Y	Covono	LVY AU	tany 1	250	Zersp 7	PG	HSG	7000	2□ No	3 Probably 4 Office
Q Q	TIL	200	4.		1		2	4a. Wes en e		24b. Were autopsy finding available prior to
Completed	- Furt	staceka	encl	19	11111			performed	11	completion of causa of death?
Eo	CTI	CATE						1□ Yes	2500	1 Yes 2 No
BeC	25. Was case referred to medic	al				26. Place	of Death (Che	ck only one)		
To	exeminer?	Hospitel:	patient 2 ER/	Outpatien	t 3 DOA Ott	her: 4 Nu	irsing Home	Residenc	a 6 DOth	er (Specify)
:uo	27. Menner of Death Netural 5 ☐ Pend	28a. Date of	f Injury 28t	b. Time of Injury	28c. Inju Wo	ry et ork?	28d. E	escribe how	Injury occur	red
catle	2 Accident invest	tigation			M 1	Yes 2				
E	3 Sulcide 6 Could determ	mined 200. Flebe	of Injury - At home, g, etc. (Specify)	, farm, str	eet, factory, offica			ocation (Stree ity or Town, S		per or Rural Route Number,
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(13	29a. Certifier Certifyl (Check only 2 Medica		sls of examination							enner as stated. and due to the cause(s)
=======================================	one)	and mann	or stated.					204	Data signa	
Medical Certification:		er			29c. Licens	se number		200.	mare diffic	d (Month, Day, Year)
		1115	MO		29c. Licens	470	7	200.	4/2	d (Month, Day, Year)
	29b. Signature and title of Centil	WALL I	MO)	a) (Tune	1) 2	f755	76	•	7/2	16f
		who completed cause	of death (Item 23)	a) (Type,	1) 2	f755	176 UN TC	•	7/2	16f

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

1. Deceder's Name (First, Model, Lasy) DAVID NILES PUTMAN A Facility Name (First, Model, Lasy) A Facility Name (First, Model, Lasy) A Facility Name (First, Model, Lasy) Function Fu				Cer	tificate of	Death	Re	g. No.	2301	J
Division Funeral Fu	Dhualaia									of Death
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Atlantic General Hospital Social Source Name 20 27, 26 (hyvr. and primate) 10 10 10 10 10 10 10 1	\ .	An Provide Atoms (Manakinskin miss of	reet and number)			4b. City, Town, or L	ocation of Death	4c. County of	Death	
Comment Comm			spital			Berlin		Worche	ster	
Company Comp	Funoral			s. last birthday)		If Under 24 Hrs.	8. Date of Birth			or Fore
Betty Jane Putman (Wife) 6905 100th Avenue, Seabrook, MD 20706 20b. Repaired Disposition (Warse of page) 20b. Place of Page) 20b. Place of Disposition (Warse of Page) 20b. Place of Page) 20b. Place of Disposition (Warse of Page) 20b. Place of Pa	Director	220-16-2205	4 2□ F 7	71 Yrs.	Months Deys	Hours Min.	Feb. 1	6, 1927	Maryland	
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TO T	O e de d	Part II. Other significant conditions contri	buting to death but not re	sulting in the ur	derlying cause g	iven in Pert I.	23b. Dld to	bacco usa contr	ibute to the caus	e of de
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Hospit 24 hour Funer etely fill	29a. Certifier 1 Cartifying Physic (Check only one)	r: On the bests of examir	nowledge, deeth nation and/or Inv	occurred at the estigetion, in my	time, date and place opinion, death occu	, and due to the corred et the time, d	euse(s) and manr ate and plece, an	ner as stated. d due to the caus	e(s)
	o this				29c. Licer	nse number	2	9d. Date signed	Month, Day, Year)
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30. New a and eddress of person who completed cause of death (Item 23e) (Type, Print)		30 Mayle and eddress of person who com	pleted cause of death (Ite	em 23e) (Type, I	9777	HOP. 14	when A	12	clas A	10
pamela cova, NO 1133 Mentionay Dr Derlining		pamela e	ovn, N	()	1135	Meale	ray D	1 De	4 111/1	10
State State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			1.00	nature	1				0	-18

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** September 7, 1998 A.W. Rajah Ranasinghe 1:50 PM /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Dey, Year) Jan. 22, 1940 Sri Lanka If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min Months I 1 ₺ M 2 □ F Devs Hours 58 578-88-9205 **Director** Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at 1 Yes 2X No Maryland Montgomery Potomac Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 20854 1029 Willowleaf Way Sri Lanka Funeral filed within 72 hours ofter death "naturel", or items Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: South Asian 20 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 8 World Bank Executive 17. Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 8 and Mental Don Anthony Perera Ranasinghe Salome Perera Peges 1 and 2 should I sent of Health and Meni 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Health a Shaalini Ranasinghe/Daughter 1029 Willowleaf Way, Potomac, Maryland item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 10, 1998 20e. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State 보호 Department of Important: If any injury or unce 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501
Robert A. Pumphrey Funeral Home/Bethesda-Chevy
Chase, Inc.
Bethesda, Maryland 20814-3501
Approximate
Robert A. Pumphrey Funeral Home/Bethesda-Chevy
Chase, Inc.

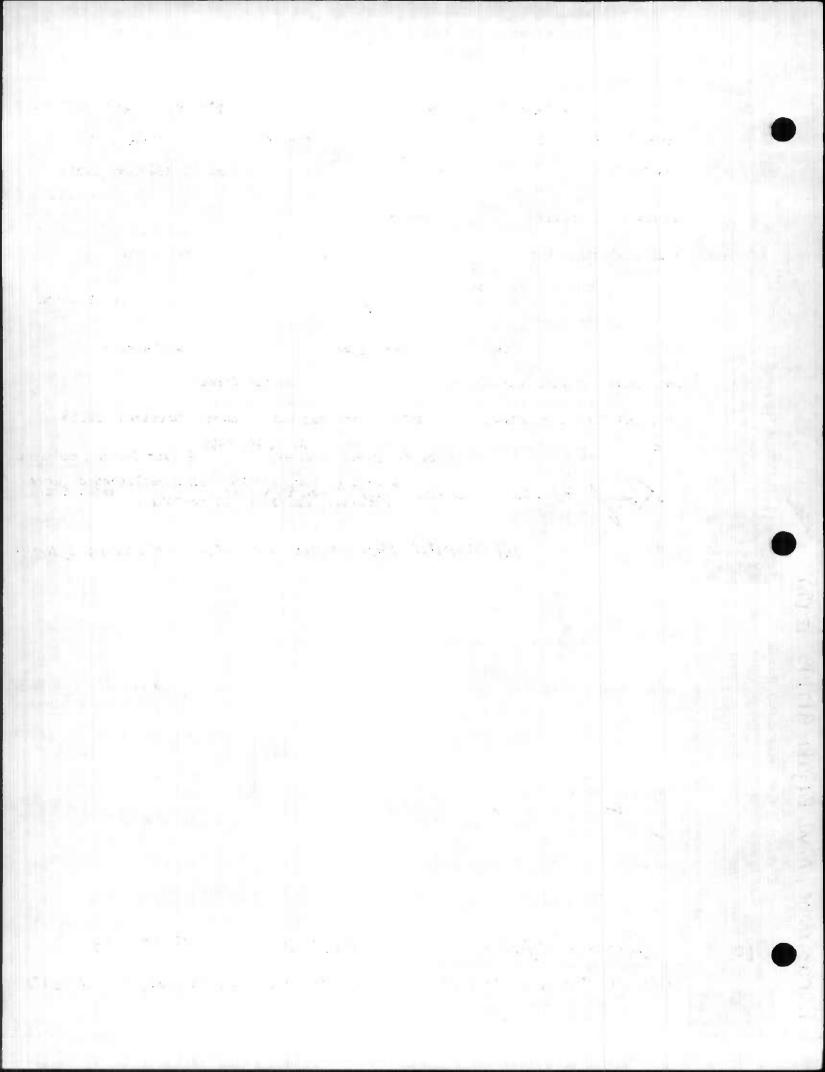
Approximate 21. Signature of Funeral Service Licensee **Physician** METASTATIC NON-SMALL CELL LUNG CARCINOMA 8 405. /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 98 USB signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificate hes b 1 Yes 2₺ No 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 NO 10 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 1 Yes 2 No 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 4 Homloide A 24 hour. 0 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated. Medicai To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 09/07/98 D2 3308 10 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) VICTOR M. PRIEGO. M.O. 6410 ROCKLEDGE DR. # 625 BETHESDA, MD. 20817 31. Date filed (Month, Dey, Year) SEP 1 1 1998 State

DHMH 16 Rev 6/95

Registrar

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anasinghe, A. W. Rajah



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey September **Physician** 8:10 PM RANSON MARY /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Hospita Regional Prince Laure George's _aure | Winder 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | MARCH 12, 1905 5. Sociel Security Number If Under 1 Year Birthplaca (State or Foreign Country)
 MISSISSIPPI 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days 1 M 2 F Yrs. 428-70-7626 Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show event, the Medical Examiner must be notified at 1 No Yes 2 No Director MD. PRINCE GEORGES BELTSVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò Items 23s 20705 U.S.A. 13115 GREENMOUNT AVE. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Bace - American Indian Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: p 3 Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) HOSPITAL NURSE 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be J. W. HULL PATSY H. YOUNG 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JAMES W. HULL/NEPHEW AS ITEM SAME 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date permit. Pages 1 Department of H Important: If its any Injury or ot once. 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) CHAMBERS CREMATORY 19/10/98 RIVERDALE. MD. 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical 220915 Examiner Due to (or es a consequence of): -Examiner ecusions Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Box 68760. PlearA Physician/Medical Due to (or es a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown aserber been signed be det þ Records. 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No 1 12 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Naturel 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Discompletely filled in Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. Medicai 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 013687 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Determine D. Mac May Must Determine 11701. Dog Bur Baltiulle mo

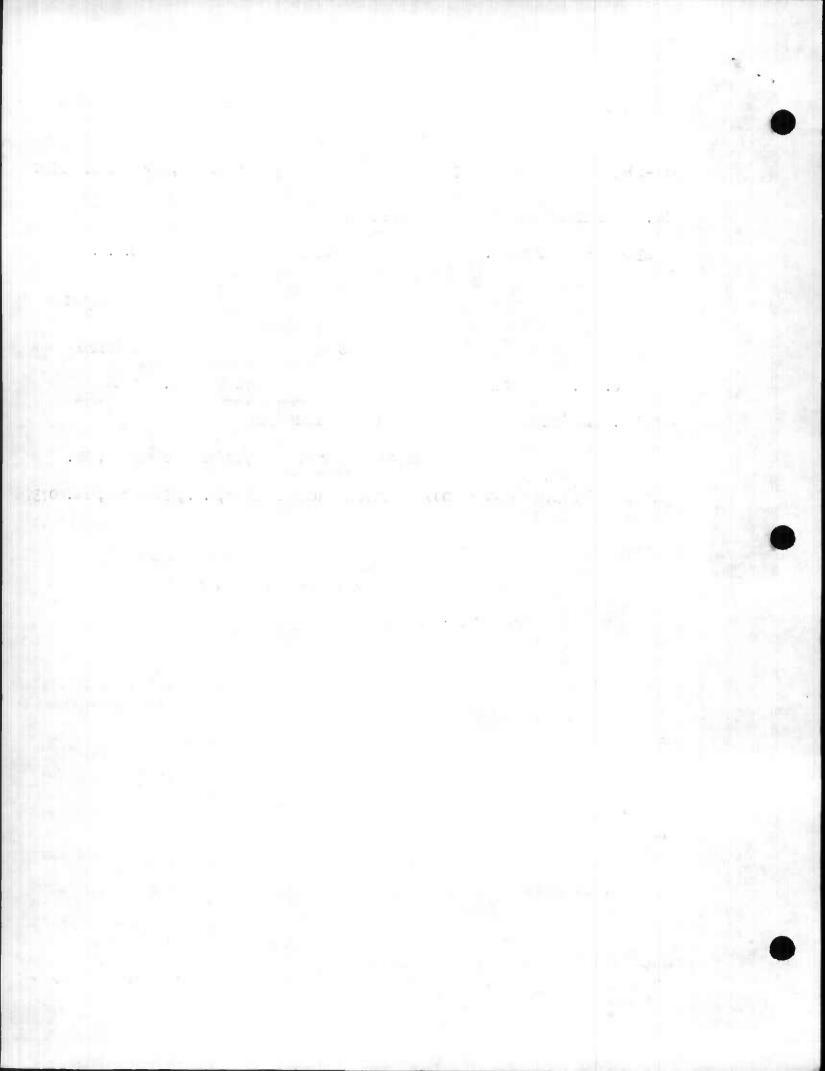
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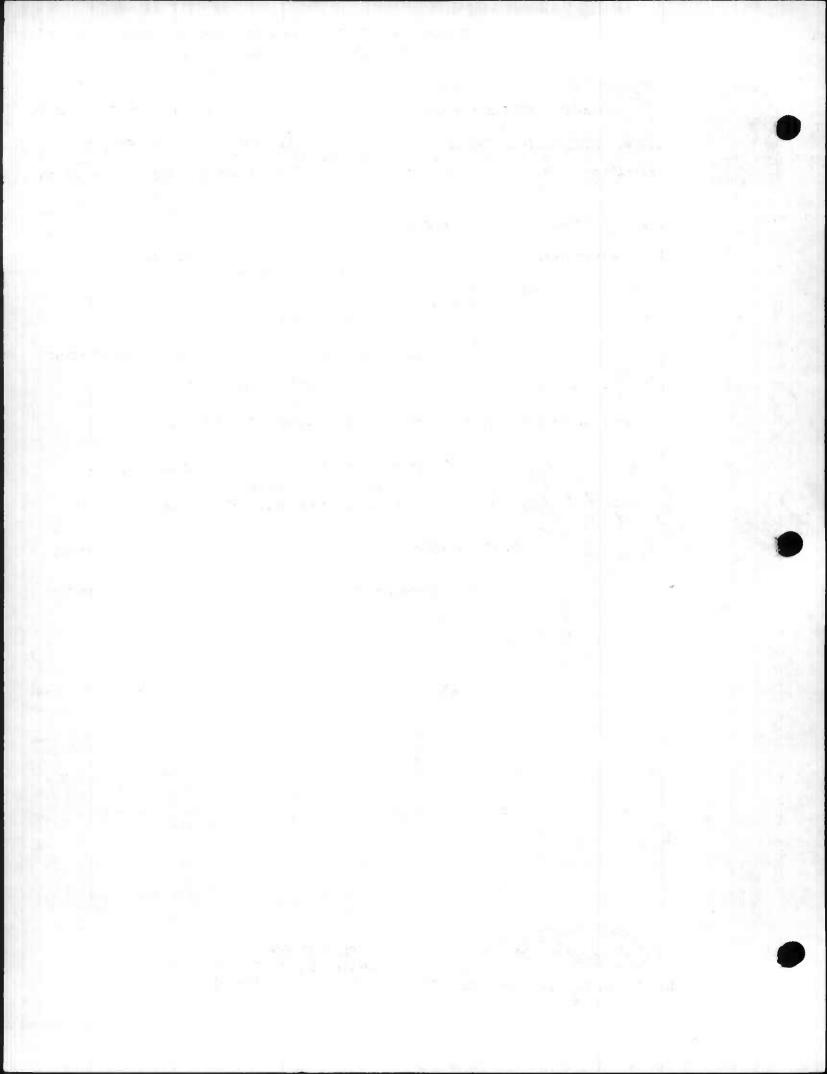
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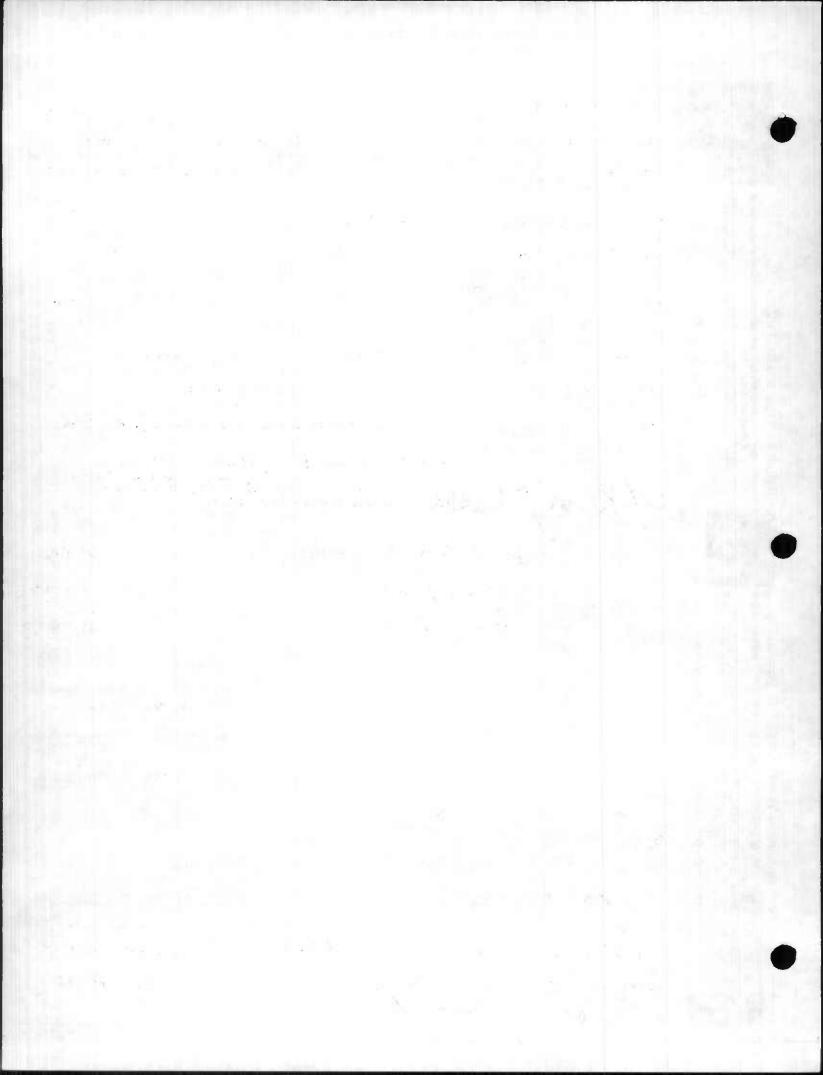
State of Maryland / Department of Health and Mental Hygiene

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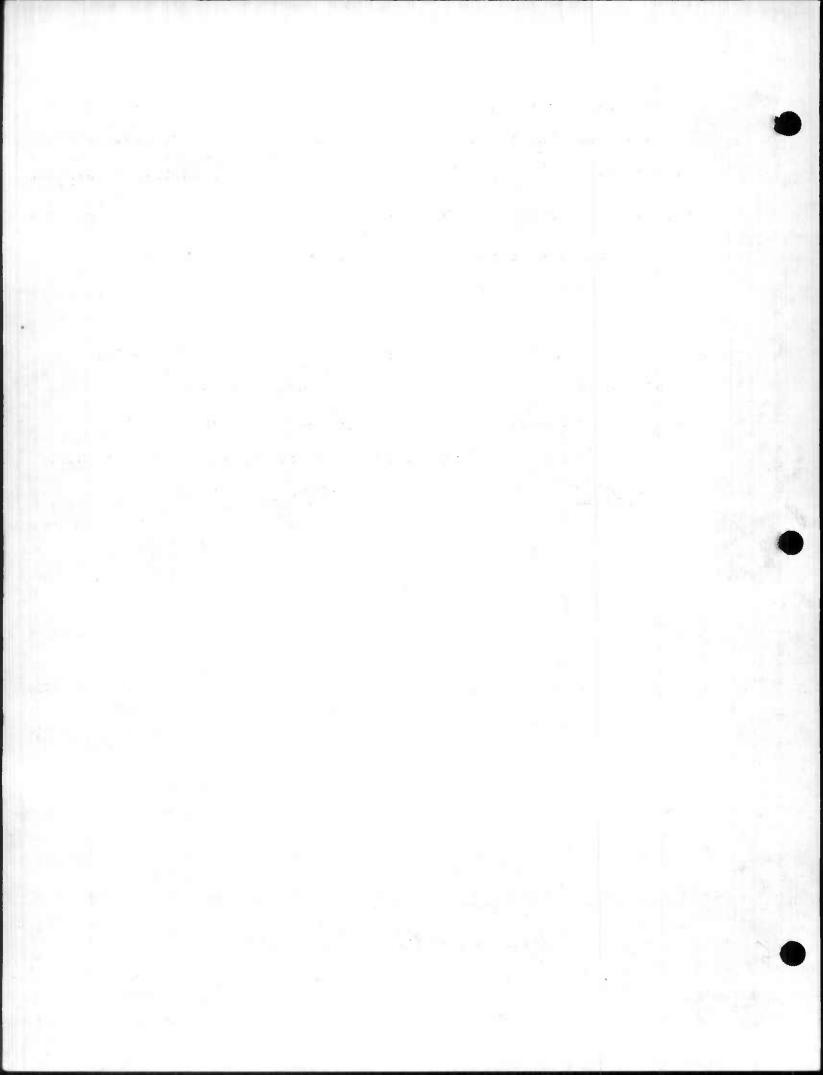
State of Maryland / Department of Health and Mental Hygiene

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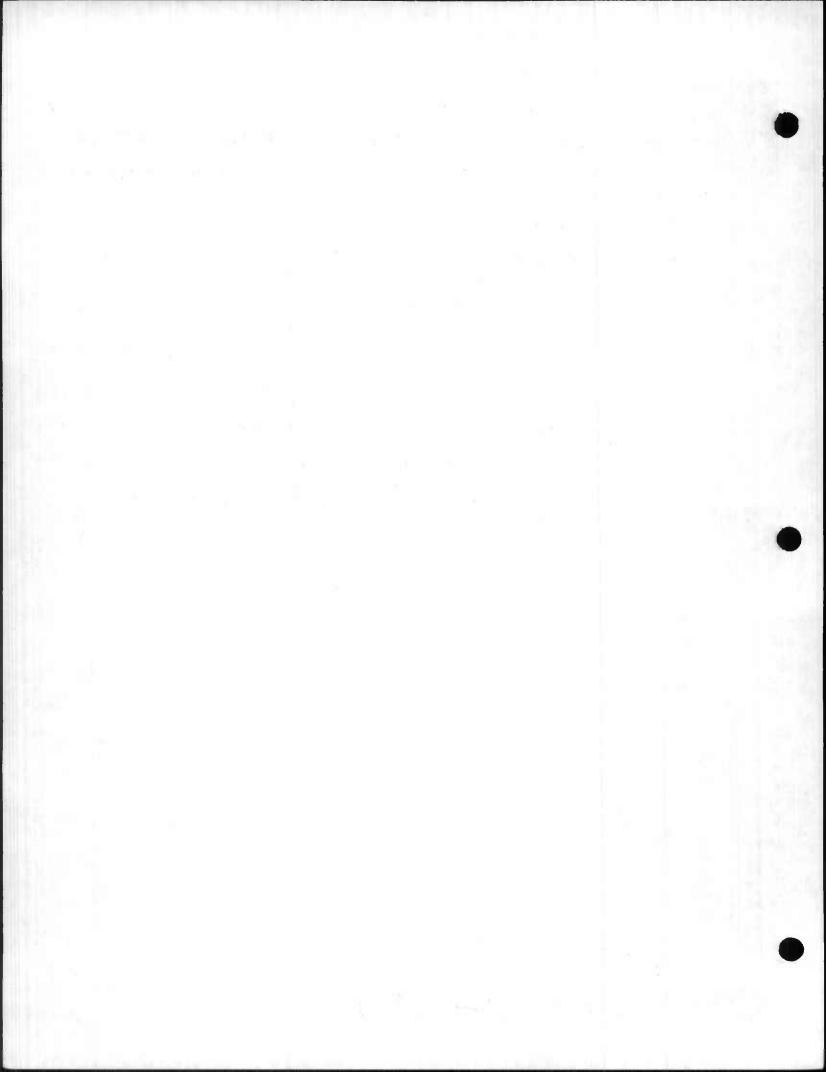
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State of Maryland / Department of Health and Mental Hygiene

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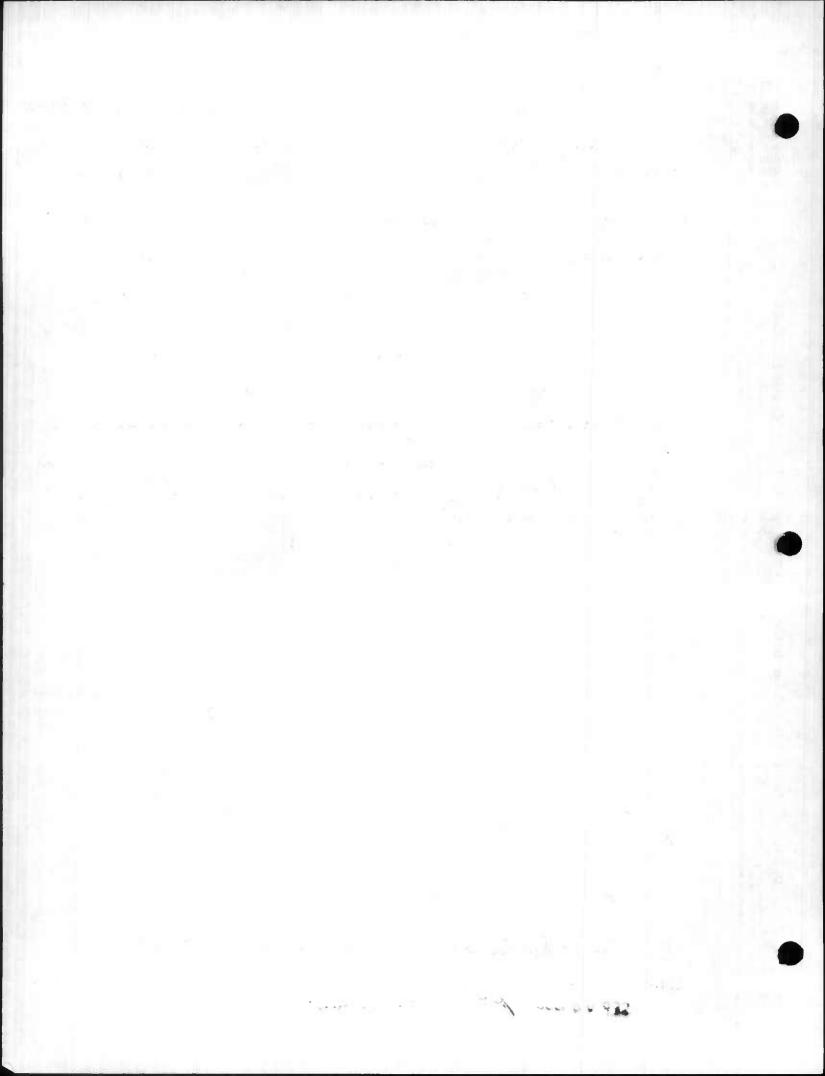
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72 hours effer death with the Maryland natural, or items 23a or 28a-f show sical Examiner must be notified at	by Funeral	11. Meritel Status 1 □ Never Merried 2[3 ☑ Widowed 4 □ Dri		12. Wes Decedent Armed Forces' 17 Yes 2 If Yes, Give Yeer or Datas:	7	1 D Y	Decedant of F , specify Cub as 2 No	Hispanic Origin? (ean, Maxican, Pue Specify:	Specify Yes or Norto Rican, etc.)		Rece - Amari Black, White, eclfy:	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:35 AM VAN CRAIG September 6, 1998 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 123 West Baltimore Road Taneytown Carroll 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | if Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Yrs. July 29, 1934 Director 219-34-9533 62 Maryland Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1□Yes 2□No Director Maryland Carroll Taneytown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or items 23s or item yor other thaumatic event, the Medical Exertine man 123 West Baltimore Road 21778 Funeral United States 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. XYes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White þ Specify: 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Auto Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Apple Church Road #7 Bonnie Morris, daughter Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burlal 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 9/10/98 Rockville, Maryland Parklawn Mem Park 21. Signature of Egheral Service Licensee 22. Name and Address of Fecility Stauffer Funeral Home 104 East Main Street Thurmont, Maryland 21788 and the causad the math. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical lung Cancer Immediata Cause (Final disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last pue buriel-trer Due to (or as e consequenca of): P.O. Box 68760, Physician/Medical the Due to (or es e consequence of): for use as ettending signed by the eld Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Records, 99 ð 24b. Were autopsy findings evailable prior to page 2 should Completed 24a. Was en eutopsy completion of cause of deeth? 1 Yes 20 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4□ Nursing Home \$\$\text{Residence}\$ Residence 8 □ Othar (Specify) 2 1 Yes 2 No After this funeral 27. Manner of Death Dete of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No within 24 hours efter deeth. To the Funeral Director: A filled in by the 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homleide Certifying Phyalcian: To the best of my knowledge, death occurred at tha tima, date and place, and due to tha causa(s) and mannar as stated.

| Certifying Phyalcian: To the best of my knowledge, death occurred at tha tima, date and place, and due to the causa(s) and manner stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the causa(s) and manner stated. 29a. Certifier completely (Check only one) the state of 29b. Signature and titla ofscertifie 29c. License number 29d. Date signed (Month, Day, Year) 3 M 30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print) Street Frederick MD 21701 7th MD 501 Eskander 31. Date filed (Month Alandr's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Beryl Eugene Rosier \$EPTEMBER 15,1998 8:14PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) NOV. 3, 1923 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Months Days 1 MM 2□ F Hours 74 193-18-6365 Pennsylvania Director Usual Residence of Decadent the Marylend 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23s or 28s-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Baltimore MD Director Parkton 10e. Street and Number * 10f. Zip Code 10g, Citizen of What Country? 18723 York Road 21120 U.S.A. Funeral 14. Raca - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces?

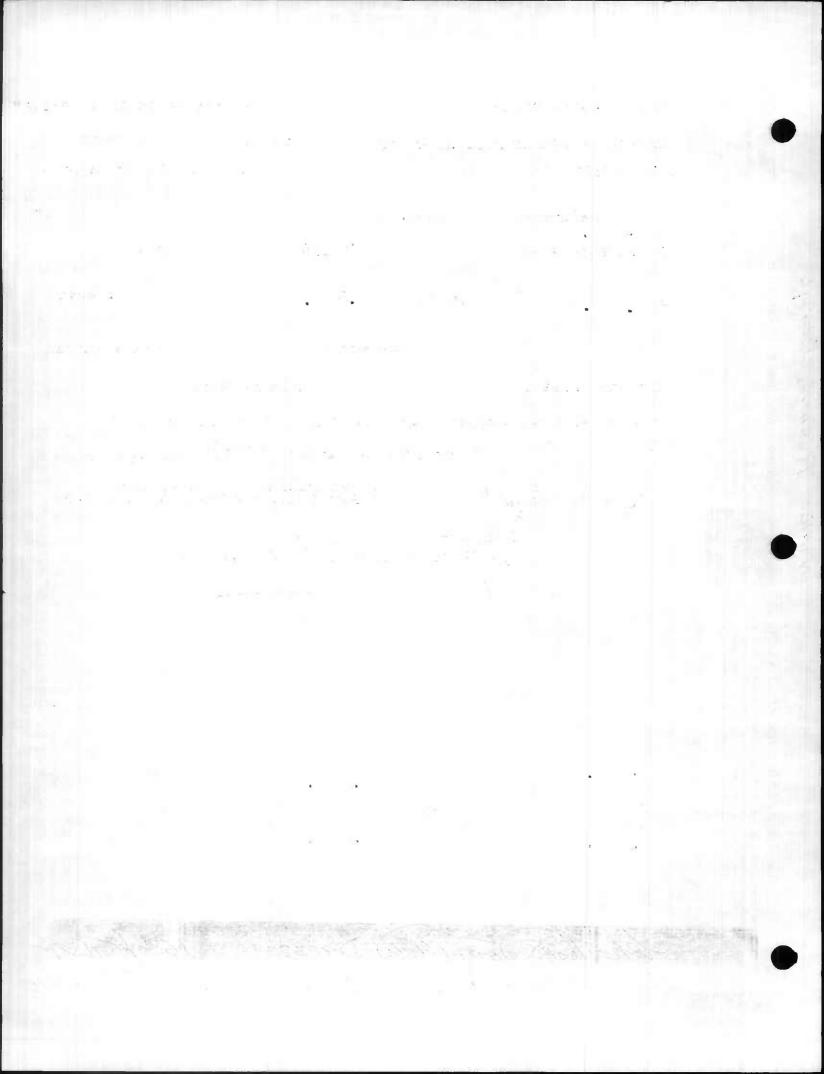
1 ∑ Yes 2 □ No If Yes, Give Tatla7 T Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 White Specify: 2 3 Widowed 4 □ Divorced Yeer or Dates: WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 end 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Tool Manufacturing Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Clarence Rosier Almeta Gemmill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Darla B. Williams/Daughter 2329 Bond Rd., Parkton, MD 21120 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept. 20, 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State Injury or New Freedom Cemetery Depertment if important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 1998 New Freedom, PA 21 Signature of Funeral Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc 24 Second St., New Freedom, PA 17349 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Onset and Death **Physician** dio Renal /Medicai Immediate Ceuse (Finel 1030/0011 disease or condition resulting in death) **Examiner** Due to (or es a consequenca of): Examiner JSCULON pue buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) physician the death certificate be Physician/Medical the Due to (or as a consequence of) 80 esn ŏ signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Onknown 1 Yes 2 No Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peeu page 2 hes 1 Yes 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: director 25. Was case referred to medical Be 26. Placa of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 PER/Outpatient 3 DOA this funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28b. Time of After 1 Natural 5 Pending investigation injury death. 1 Yes 2 No 2 Accident Offector: 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide completely filled Hospital 24 hours 6 24 hours 1 Phyeician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated. 29a. Certifier Medical within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number n 23a) (Type, Print) Hampet HillRd State

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Anthony John Rudez Jr. August 31
4b. City, Town, or Location of beath 4c. C 12:00pm 1998 /Medical 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 7008 Willowtree Dr. Middletown Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 28, 9. Birthplaca (State or Foreign Country)
Pa• 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1X M 2□ F Yrs. Director 195-40-5981 49 Usual Residence of Decedent with the Marylend r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Md. Frederick Middletown ecto 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 급 "natural", or items 23a or addical Examiner must be r 7008 Willowtree Dt. 21769 U.S.A. death ! Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or her any injury or other traumatic svent, the Medical Examina page. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) federal gov't. 4 asst. comptroller 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Anthony John Rudez Sr. Rose Marrie Ward 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony J. Rudez III (Son) 7008 Willowtree Dr., Middletown, Md. 21769 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spacity) Reformed Cemetery 9/5 Middletown, Md. 22. Name and Address of Facility
Donald B. Thompson Funeral Home 21. Signature of Funeral/Service Licensee 23a. Part T. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Betw Onset end Death **Physician** Asphyxiation /Medical Immediate Cause (Final disease or condition resulting in death) immediate Examiner Due to (or as a consequence of): Examiner physician and the buriel-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): for use es by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 2 Depression signed b þ 24b. Ware autopsy findings evelleble prior to completion of cause of death? should t 24a. Was an autopsy performed? Completed hes certificate he irector, pege 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: After or Attending 5 Pending Investigation Carbon monoxide poisioning 1 Natural Aug. 31, 1998 12 p. M . 1 1 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 1 Yes 2 □NO death. ector: A 2 Accidant 3 Suicide 6 Could not be datermined 28f. Location (Street and Number or Rural Route Nu City or Town, State) within 24 hours efter To the Funeral Direc completely filled in b Direc 4 Homicida 700 8W:110W 1160 home 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) and manner stated. (Check only one) To the F within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 4, 1998 and address of person who completed cause of death (Item 23a) (Type, Print) W. Patrick St Fredoride, MD21703 MD FI. 1080 Andrew ARICK 31. Date filad (Month, Day, Year) 32. Registrar's Signature

State Registrar

0 8 1998

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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'à Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day **Physician** Reiner E 6 pm Laurence 4b. City, Town, or Location of Deeth 1998 4c. County of Deeth /Medical 4e Facility Name (If not institution, give street and number) Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days MM 2DF Months Hours Min. 93 Director 113-12-7498 Nov 14 1904 NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Medical Examines must be notified at MD Montgomery Boyds 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16776 White Store Rd. 20841 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Meritel Stetus permit, Pages 1 and 2 should be filed within 72 hours effer c Department of Heelin and Mentel Hygiana. Important: if itam 27 is merked other than "natural", or iten any injury or other traumetic event 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White ò 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) engineer Equitable Life 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be n/a n/a 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $Boyds \;\;\text{MD} \;\; 20841$ 19a. Informent's Neme/Relationship (Type, Print) Boyds, god daughter Susande Messieres 16776 White Store Rd
Dete 20c. Location - City or Town, State Susande Messieres/ 20e. Method of Disposition 1 ☐ Burial 2 IX Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg 8/29 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Hilton Funeral Home 0 Will 23a. Part1. Entar tha disaasa, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete fntarval Batween Onset end Death **Physician** /Medical Immediata Causa (Final Cardiac disease or condition rasulting in death) Examiner Examiner cal cemia physician and the burial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or as a consequence of): 60 USB for 23b. Did tobacco usa contribute to the cause of death? e deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by to d be detect 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara eutopsy findinga eveilable prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? hes pege 2 1 Yes 2 No 1 Yes 2 No certificate 25. Wes case referred to medical exeminer? funeral director. Be 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA 1 Yes /2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Natural 1 Yas 2 No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 3 4 Homlcide 12 Certifying Physician: To tha best of my knowledga, death occurred at the time, dete and place, end due to the cause(s) and manner as steted. 29a. Cartifier Medical

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

deeth with the Meryland

Baltimore, Maryland 21215-0020

 Hospital or Attending Physician:
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> State Registra

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(Check only one)

29b. Signeture and title of certifier

30. Name and address of person who complated ceusa of death (Item 23e) (Type, Print)

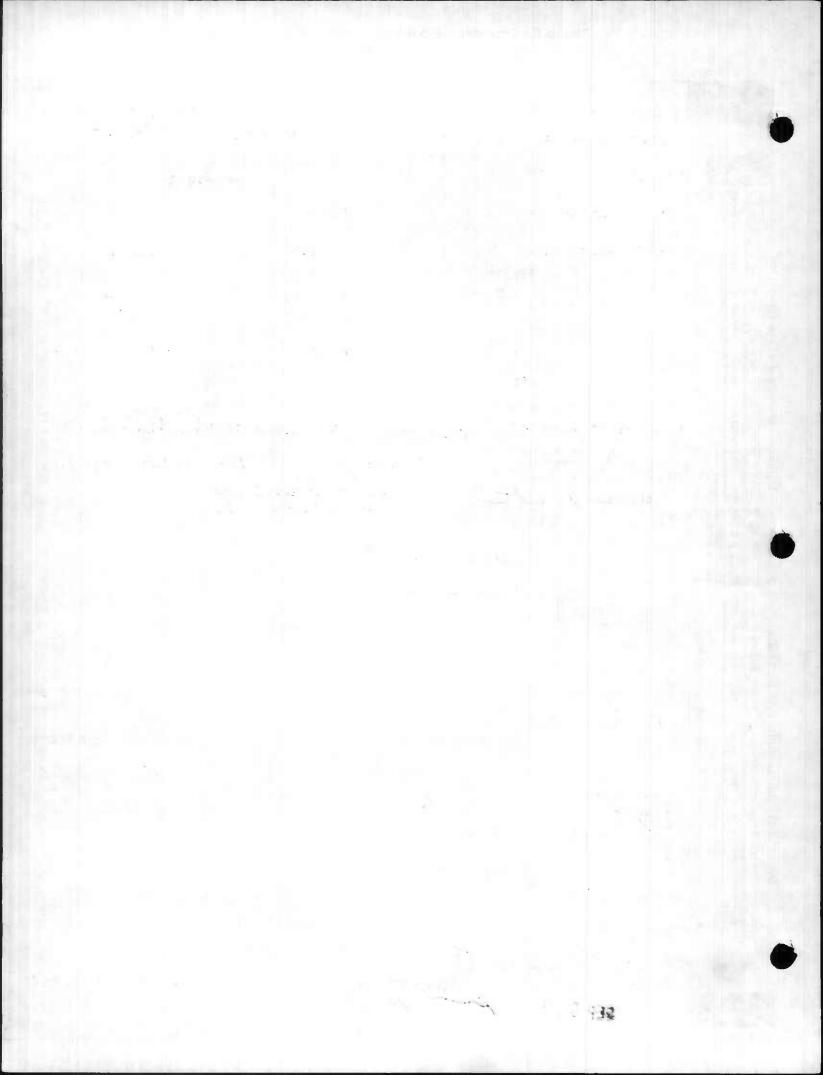
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mennar stated.

29c. License number

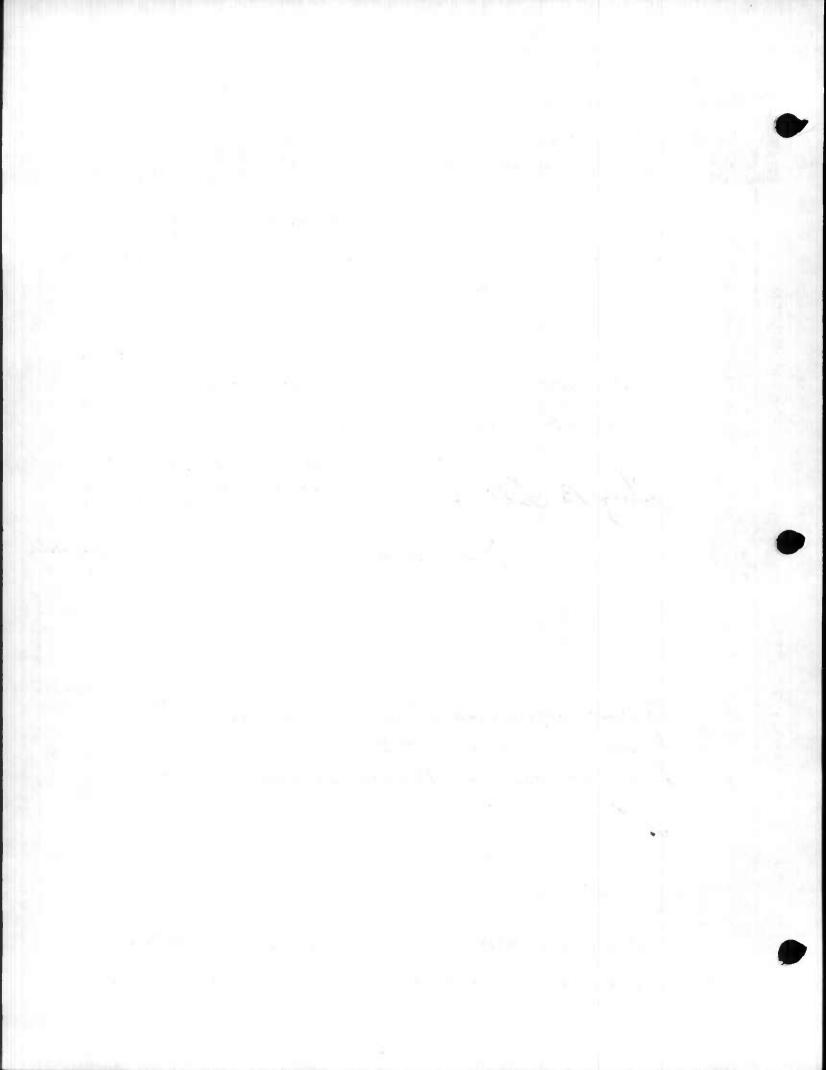
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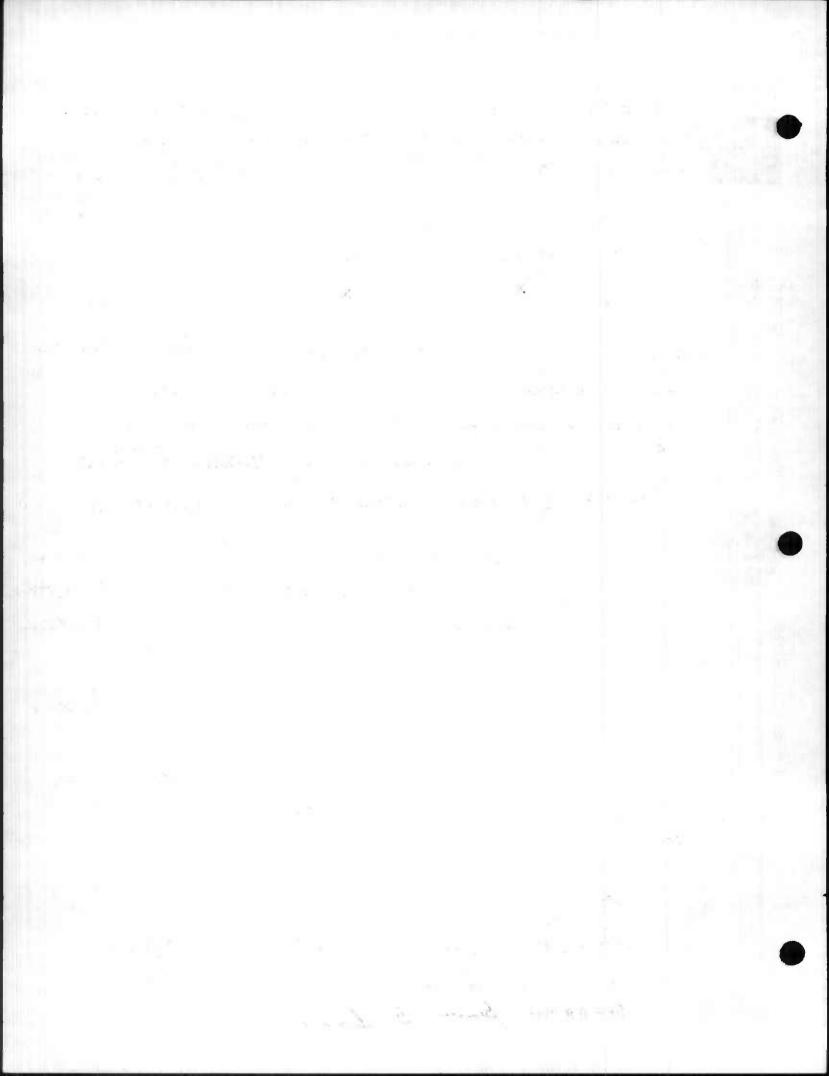
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Department of Health end Mental Hygiene. Important: If Item 27 is merked other than "natur any Injury or other traumatic event, Ite Medical once.		19a. Informant's Name/Ralationship (Type, Print) Mary Carolyn Hopkins/Sist 20a. Mathod of Disposition 1 ⊠ Burial 2 □ Cramation 3 □ Ramoval from Sta 4 □ Donation 5 □ Othar (Spacify) 21. Signalura □ Friaral Sarvice Licensaa	20b. Placa of Discamatary, cr Chesterf	O. Box 127 position (Nama of rematory or other platical Cemet 22. Nama and Addra	7, Crumpt co) cery/Sept	on, Mary Data ember 10		3
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ata has been sign page 2 should be		Parkinsons des PEG-tube Freder	ine, the	pertens Loves o	s of Ke	1 □ Yo	n autopsy 24b.	
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within 24 hours after deeth. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	To Be Completed	PEG- Hube Feedur 25. Was casa rafarred to madical examinar? 1	atiant 2 ER/Outpatiniury Day Year) 28b. Tima Injury Injury - At homa, farm, satc. (Spacify) st of my knowledga, dae of axamination and/or stalad.	tent 3 DOA Other of 28c. Injury World M 1 Destraat, factory, office	26. Placa of Dea nar: 4 Nursing H y at k? Yas 2 No	24a. Was an perform 1 Ya th (Check only on ona 5 Rasida 28d. Dascribe ho 28f. Location (St. City or Town and dua to tha cared at tha tima, da	n autopsy 24b. as 2 No e) ance 6 Othar (Sprow Injury occurred reat and Number or F., Stata)	Wara autopsy finding available prior to completion of causa of death? 1 Yas 2 No ecify) fural Routa Number, as stated, a to the causa(s)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Hollis Tony Robinson 5,1998 Sept. 1:05 PM /Medical 4a. Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Daeth 4c. County of Death **Examiner** Chestertown Nursing & Rehabilitation Chestertown Kent 7. Aga (In yrs. last birthday) | If Undar 1 Yaar | If Undar 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foreign Country) **Funeral** 12M 2 F 218-34-3093 **Director** 58 Apr.16,1940 Maryland Usual Rasidanca of Decedent the Merylenc 10a, Stata 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 10d. Insida City Limits 1 Yes 2 No Director Md. Kent Chestertown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 327 Lord Calvert Garden 21620 death Funeral USA 12. Was Decedant Ever in U,S. Armed Forcas? 1 Ayas 2 □ No If Yas, Giva Yaar or Dates: 5 Dac. 58 14. Race - American Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, atc.) Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours efter Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Fernance. 1 ☐ Naver Merriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 Widowed 4 Divorced Black Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Joseph Rizzo &Son 12th Construction 17. Father's Nama (First, Middle, Last) 18. Mothar's Nema (First, Middla, Meidan Sumeme) Hollis G. Robinson Thelma Edna Williams 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Mrs. Shiela Wesley(Daughre) 25559 Goldsboro)Henderson, Md. 21640 20b. Placa of Disposition (Nama of cemetery, cramatory or other place) 20c. Location - City or Town, Stata (Pomona) 20e. Method of Disposition 156 Buriai 2 ☐ Cramation 3 ☐ Ramovel from Stata 4 □ Donation 5 □ Other (Spacify) Emmanuel U.M.Cem. 9-12-98 Chestertown, Md. 21. Signatura of Funaral Sarvica Licensae 22. Nama and Address of Fecility WALLEY FUNERAL HOME Chestertown, Md. 21620 23a Part Lenter the chaese, or complications that caused the death. In not antar the mode of dying, such as cardiac or respiretory arrast, shock, or hand failure. List only one ceuse on each line. Approximata Intarval Between Onset end Deeth **Physician** /Medical Immediata Causa (Final disaase or condition rasulting in daath) Examiner Examine ances physician end the buriel-transit Sequantially list conditions, if any, laading to Immadiata cause. Enter Undarlying Causa (Disaasa or injury that initieted avants resulting In daath) Last Due to (or as a consaquanca of): P.O. Box 68760 the death certificate be Physician/Medical 98 ettending use 5 been signed by the e should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Records, by 24a. Was an autopsy performed? Wara autopsy findings eveilable prior to Completed completion of causa of death? hes 1 Yas 220No certificete Division of Vital Attending Physician: funeral director, 25. Was casa referred to medical axaminar? Be 26. Placa of Daath (Check only one) 1 Yas 2 Othar: Nursing Home 5 Residence 6 Other (Specify) 1 inpatiant 2 ER/Outpatiant 3 DOA this 28e. Deta of Injury (Month, Dey Year) 27. Mennar of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending Invastigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur 1 Yas 2 No 3 Suicide 6 Could not be detarmined 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homloide edicai Certifying Physician: To tha best of my knowledge, death occurred at tha time, data and piece, and due to tha ceuse(s) and menner as steted.

Medical Examinar: On tha basis of axamination end/or invastigetion, in my opinion, daath occurred at tha tima, data and piaca, and dua to tha cause(s) end mannar stated. 29a. Certifier (Check only one) 29b. Signatura and title of confine 29c. Licanse number 29d. Data signed (Month, Day, Yaar) Cole 0 2 Churchhell Rd Chestertown MD 30. Name and addrass of person who complated cause of de (Itam 23a) (Type, Print) MD Frederick 32. Ragistrar's Signatura 31. Data filed (Month, Day, Yaar) State SEP 08 1998 Registrar

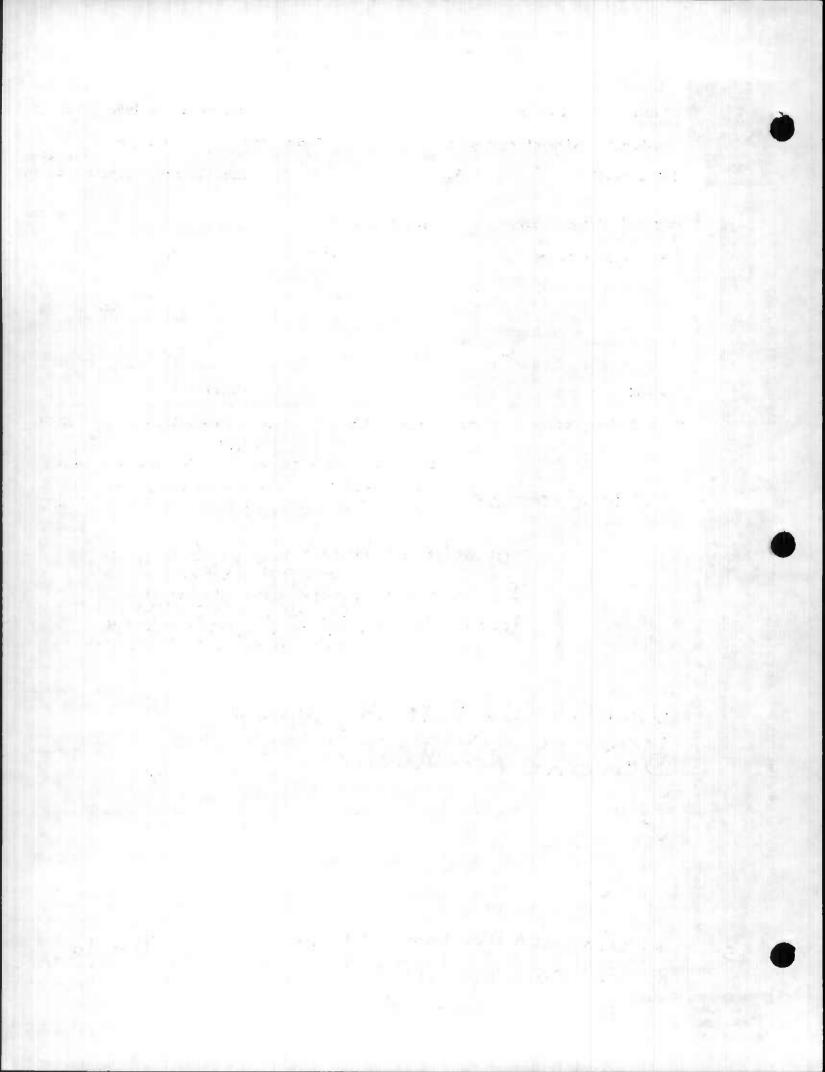


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1 Never Mei		Armed Forces?		4	20902	1	0g. Citizen of W	
(Spe		If Yes, Give Yeer or Detes:		13. Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 □XNo	ispanic Origin? (S) nn, Mexican, Puerto Specify:	pecify Yes or No- Plican, etc.)	Black	- American Indian, c, White, etc. Black
	15. Decedent's Ed		16a. I	Decedent's Usual Occup Give kind of work done	etion during most of wor	king	16b. Kind of Bus	siness/Industry
Elementery/Sec	condary (0-12)		-}				II S	Government
17. Father's Neme	(First, Middle, Last)		1 00	Miputer 5				
Rich	ard Spel	ler		Water State	Amar	nda Out	law	
19a. Informent's N	lame/Reletionship (7	Type, Print)						
Betty	L. Spell	er (Wife) 30	005 Hardy	Ave., S	Silver	Spring	, MD 20902
		Removal from State	20b. Place of l	Disposition (Name of crematory or other place	xe)	Date	20c. Location - 0	City or Town, Stete
			Cherry	Funeral	Home 9	/17/98	Winds	sor, NC
21. Signature of F	uneral Service Licen	me	ween			L HOME 20850	, P.A.	
23a. Part1. Enter shock, or he	the disease, or compendate the compensation of	plications thet caused one ceuse on each line	the death. Do no	ot enter the mode of dyin	g, such as cardiac	or respiratory err	est,	Approximete Interval Between
diseese or conditi	on	. Met	asta	tic Car	ncer			Onset and Death
	8-2-7		Due to (or as a co	onsequence of):				
Sequentially list c	onditions,	b	Due to (or as a co	onsequence of):				
Cause (Diseese of that initiated even	lerrying r injury ts Lest	c	Oue to (or as a co	insequence of):				
	-	d						
Pert II. Other sign	ificant conditions of	ontributing to death but	t not resulting in	the underlying cause giv	en in Part I.	23b. Did to	obacco use con	tribute to the cause of death?
						101	es 2 No	3 Probably 4 Unknown
Diabe	etes M	Pellitus						24b. Were autopsy findings aveilable prior to completion of cause of death?
HYDE	itensio	M-Sevi	ere.			1 🗆 Y	es 25 No	1 ☐ Yes 2 No
					26. Place of Dea	th (Check only or	ne)	
1 Yes 2	th	28a. Date of Injun	28b. Ti	Datient 3LJ DOA	4 LI Nursing H			
2 Accident	Investigetion	9		M 1□				
4 ☐ Homicide	determined	28e. Place of Inju	ry - At home, fan (Specify)	m, street, fectory, office				er or Rural Route Number,
29e. Certifier (Check only one)	Certifying Phy	niner: On the basis of	examination and	or investigation, in my o	pinion, death occu	rred et the time, d	ate and place, e	nd due to the cause(s)
29b. Signeture and	d title of certifier	Par	ND			2	9d. Dete signed	(Month, Day, Year)
ug	are if	, vo vac	トレン		10101	M	1-0-	10
				**	e., Sil	ver Spr	ing, M	D 20910
31. Dete filed (Moi	nth, Day, Year)	32. Registra	's Signature	1 /				
	Elementery/Sec. 17. Father's Neme Rich. 19a. Informent's Nature of Dial Burial 2 4 Donetion 21. Separature of Father shock, or he temperature of Father Understand Sec. Enter Understand Cause (Disease or condition of the temperature of Father Understand Cause (Disease of the time of the temperature of the temperat	17. Father's Neme (First, Middle, Last) Richard Spel 19a. Informent's Name/Reletionship (Betty L. Spell 20a. Method of Disposition 1 Burial 2 Cremetion 3X 4 Donetion 5 Other (Specification) 21. Signature of Funeral Service Licentary 23a. Part Enter the disease or commendate (Specification) 1 Enter the disease or commendate (Specification) 23a. Part Enter the disease or commendate (Specification) 1 Enter the disease or commendate (Specification) 23a. Part Enter the disease or commendate (Specification) 24 Enter the disease or commendate (Specification) 25 Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest 25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending Investigation (Check only 2 Accident 3 Suicide 6 Could not be determined) 29e. Certifier (Check only 2 Madical Examone) 29b. Signeture and title of certifier 30. Neme and indress of person who Gail J. Povan 31. Dete filed (Month, Day, Year)	Richard Speller 19a. Informent's Name/Reletionship (Type, Print) Betty L. Speller (Wife 20a. Method of Disposition 1 Burial 2 Cremetion 3\(\) Removel from State 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part Letter the disease, or complications that caused shock, or hear future. List only one ceuse on each line timediate Cause (Final disease or condition resulting in death) 1 1 1 1 1 1 1 1 1	Richard Speller 19a. Informent's Name/Reletionship (Type, Print) Betty L. Speller (Wife) 20a. Method of Disposition 1	Richard Speller 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street 3 0.05 Hardy 2.0a. Method of Disposition 1	17. Father's Name (First, Middle, Last) 18. Mother's Name Richard Speller 19. Informati's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Ru Betty I. Speller (Wife) 3005 Hardy Ave., Selection 19b. Mailing Address (Street and Number or Ru Betty I. Speller (Wife) 3005 Hardy Ave., Selection 19b. Mailing Address (Street and Number or Ru Betty I. Speller (Specify) 3005 Hardy Ave., Selection 19b. Mailing Address (Street and Number or Ru Betty II. Street Indianal 19b. Mailing Address (Street and Number or Ru Betty III. Street Indianal 19b. Mailing Address (Street and Number or Ru Betty III. Street Indianal 19b. Mailing Address (Street and Number or Ru Betty III. Street Indianal 19b. Mailing Address (Street and Number or Ru Betty III. Street Indianal 19b. Mailing Address (Street and Number or Ru Betty III. Street Indianal 19b. Mailing Address (Street and Number or Ru Betty III. Street Indianal 19b. Mailing Address (Street and Number or Ru Betty III. Street Indianal 19b. Mailing Address (Street and Number or Ru Betty III. Street Indianal 19b. Mailing Address (Street and Number or Ru Betty III. Street Indianal 19b. Mailing Address (Street and Number or Ru Betty III. Street Indianal 19b. Mailing Address (Street and Number or Ru Betty III. Indianal III. I	17. Father's Name (First, Modile, Last) Richard Speller Richard Speller Amanda Out Amanda Out Amanda Out Amanda Out Speller (Wife) 3005 Hardy Ave., Silver 3005 Hardy Ave., Silver	17. Father's Name (First, Meddis, Jass)

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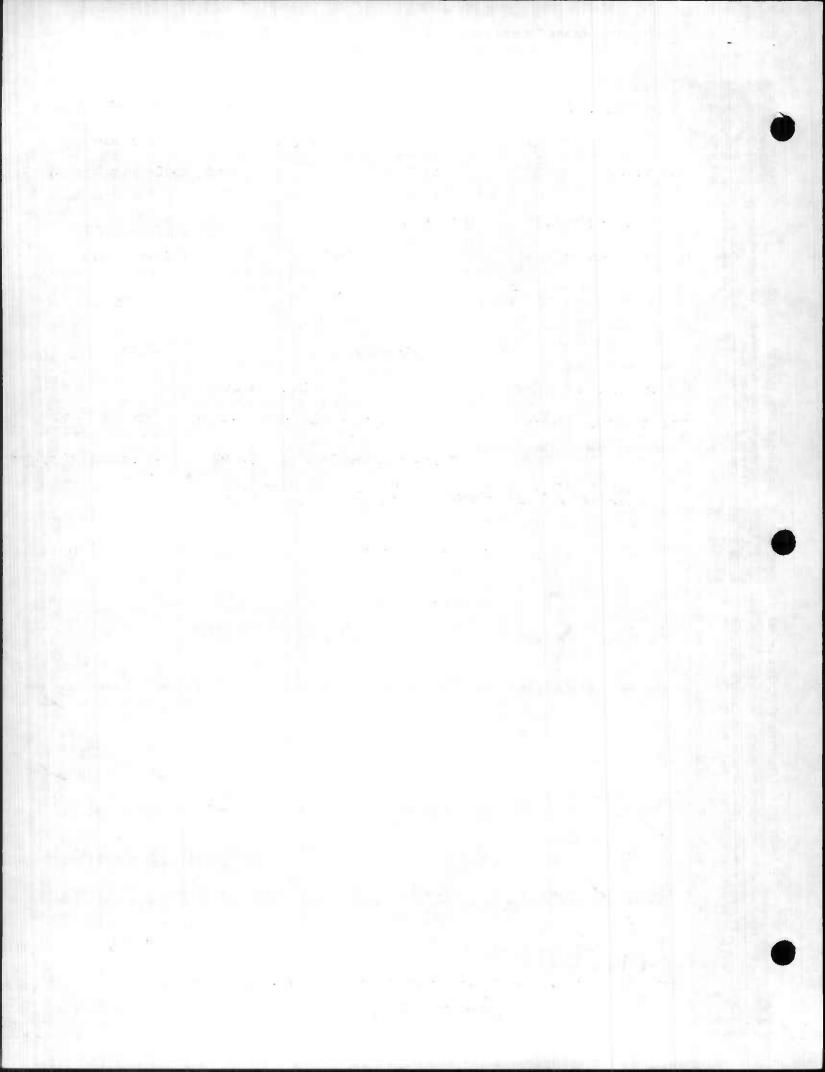
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## Account of Death 4s. County of Death		1. Decedant's Name (First, Middle, Last)	2. Data of De		Vaca	3. Time of Death	
Washington Adventict Hospital Takem Park Washington Adventict Hospital Takem Park Nonte Park Non		Kenneth I. Spicer				2:20 PM	
Social Security Number 1. Security Number 1. S		la Fecility Name (If not institution, give street and number) 4b. City, Town, C	r Location of Deat	h 4c. County o	of Death		
Top The periodene of Decoration Top							
Table Tabl	ı	Months Days Hours Mi	n. 8. Date of Bir (Month, De	rth ay, Year)	9. Birthpla Count	aca (State of Eoraign	
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Rolland Spicer 19e. Introment's NemeRelationship (Type, Print) 19c. Mealing Address (Street end Number Rural Rouse Number, City or Town, Stete, Zip Code) 19c. Mealing Address (Street end Number Rural Rouse Number, City or Town, Stete, Zip Code) 19c. Mealing Address (Street end Number or Rural Rouse Number, City or Town, Stete, Zip Code) 19c. Mealing Address (Street end Number or Rural Rouse Number, City or Town, Stete, Zip Code) 19c. Mealing Address (Street end Number or Rural Rouse Number, City or Town, Stete, Zip Code) 19c. Place of Deposition (Name of 19c. Date) 20. Place of Deposition (Name of 9/11/98 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Coll ins Funeral Home, Inc. 500 University Blvd W. , Silver Spring, MD 2090. 23s. Part. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 10c. Solo University Blvd W. , Silver Spring, MD 2090. 23s. Part. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 10c. Sequentially list conditions, a conditions, and any leading in death) 23c. Part. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 10c. Sequentially list conditions, and the sequence of the seq				Specify:	Whi	te	
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Roland Spicer 18e. Informant's Name/Relationship (Type, Print) Kenneth Neil Spicer (son) 29573 Edmonston Road Greenbelt, Maryland 2077(20a. Memod of Disposition 18t Burel 2 Coremation 3 Removal from State 4 Donation 6 Other (Specify) 21. Signature of Funeral Service Licensee 122. Name and Address of Facility Francis J. Collins	1	Elementary/Secondary (0-12) College (1-4or 5+)					
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Renneth Neil Spicer (son) 8957J Edmonston Road Greenbelt, Maryland 20770 200. Method of Disposition 1 (Rennet 2 Cremation 3 Rennoval from State 1 (Rennet) 2 Cremation 3 Rennoval from State 200. Place of Disposition (Name of 1 1 (Rennet) 2 Cremation 3 Rennoval from State 200. Place of Disposition (Name of 1 1 (Rennet) 2 200. Location - City or Town, State 200. Place of Disposition (Name of 1 200. Place of Disposition (Name of Disposition (Na	F			-	State Zin	Code)	-
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25. Was case reterred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death Varing Home 5 Residence 6 Other (Specify) 28a. Data of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28a. Data of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28b. Place of Death (Check only one) 27. Manner of Death Varing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred	200	Ischemic gangeone in Leg	S 24a. Wer	s an autopsy formed?	ava	ilable prior to	
25. Was case reterred to medical examiner? Yes 20 No	-	Beaching Asonthmias.	1 200		ot o	leeth?	
examiner? Yes 2 No			10	Yes 2 No	1 🗆	Yes 2□ No	
27. Manper of Death Nursing Home S Hesidenca 6 Other (Specify) 28a. Data of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 3 Suicide 4 Homicide 28e. Placa of Injury - At home, tarm, street, factory, offica 28f. Location (Street and Number or Rural Route Number or Building, etc. (Specify) 29a. Certifier (Check only one) 29a. Certifier Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		examiner? Hospital: . Other:					
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. Licensa number 29c. Licensa number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	tion	Noturel 5 Pending (Month, Day Year) Injury Work?	Zou. Describe	now injury occurr	-		
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	ertifical	3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, offica			er or Rura	l Route Number,	-
29b. Signature and title of certifier Month and A. Month MD 29c. Licensa number D2 4593 29d. Date signed (Month, Day, Year) 9, 4, 98	licai C	(Check only 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death or					
Morammed A. Morrison MD D24593 9.4.98	Me			29d. Date signed	(Month, I	Day, Year)	
		Mohammed A. Marwham MD D245	93	9,	4.0	18	2
30. Neme end eddress of person who completed cause of deeth (flem 23e) (Type, Print) M) 3331-10LEHO 1E1404 MD, 201			1331-1 YATTS	VILLE	N	ID, 20787	-



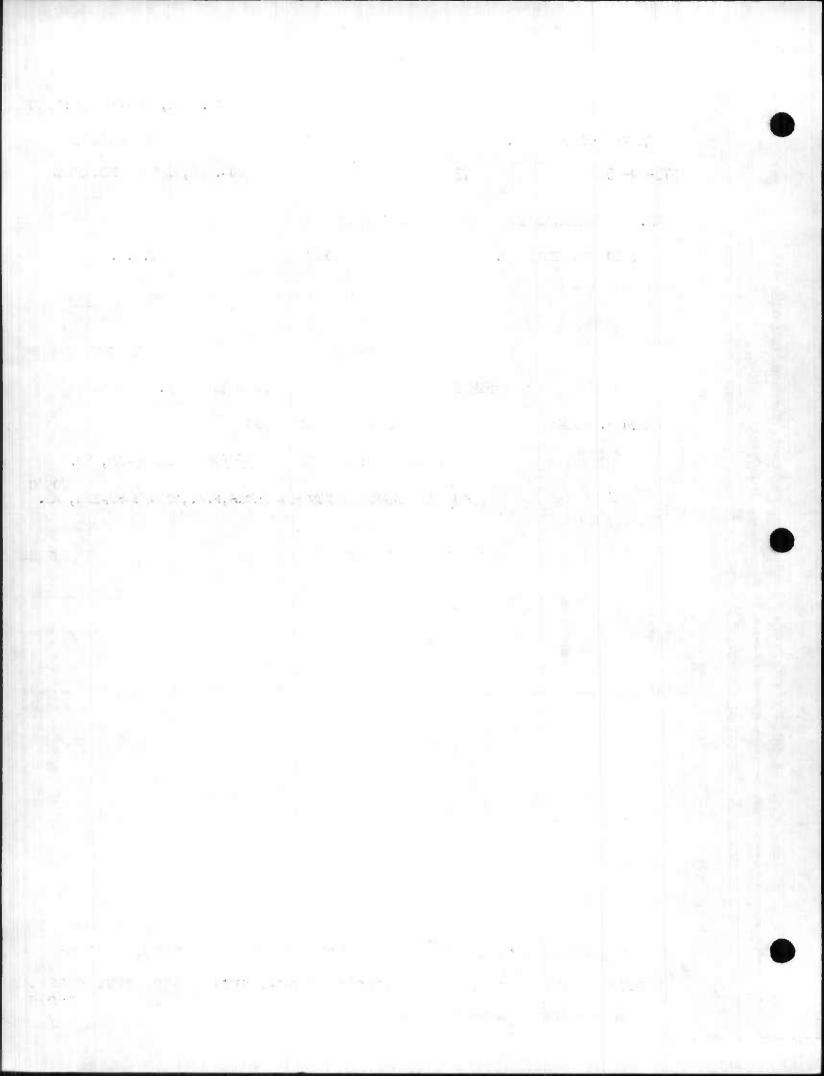
State of Maryland / Department of Health and Mental Hygiene

				Oldio of It	iai y iai				Death	Trionical Tri	Reg. No.	29090
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	Physicia /Medic		John William Sto								mber 3, 19	
N	Examin	er	4e Fecility Nema (If not institution, g		r)				4b. City, Town, o	Location of Dea	th 4c. County of I	Deeth
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L	Funeral Director		5. Sociel Security Number 6. 579-30-9409 Usuel Residence of Decedent	1⊠M 2□F	7 (lest birthdey Yrs.	Month		Hours Mir		y, Year) 1928 Wa	Birthplace (State or Foreign Country) ashington, DC
	how		10a. Stete 10b. County	70.7	10c. Cit	ty, Town or L	ocation					10d. Inside City Limits
	Be-f	cto	Maryland Montgom	ery	Ro	ckvill	e					1 ☐ Yes 2 ☒ No
	के के	Dire	10e. Street end Number					Zip Code			10g. Citizen of Whe	et Country?
	ath w	rai	11400 Strand Dri		. =			0852		0 " "	United S	tates American Indien,
21215-0020	n 72 hours efter death with the Meryland *natural', or items 23s or 28s-f show edical Experient must be norified at	by Funeral Director	11. Maritel Status 1 □ Never Merried 2 ☑ Merried 3 □ Widowed 4 □ Divorced	12. Wes Deceder Armed Forces 1 X Yes 2 If Yes, Give Year or Detes	;?] No	,5, 13.		ecify Cub	lispenic Origin? (en, Mexican, Pue Specify:	rto Rican, etc.)	Bleck, \ Specify:	White, etc.
0-0	2 ho	ted	15. Decedent's	Education		16e. Dece	edent's Us	suel Occu	petion	adina	16b. Kind of Busin	ess/Industry
21		Be Completed	(Specify only highest g Elemantary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT	usa retire	during most of w d)	DIKING		
2	filed wi Hygian ther th	Con		5+		Phys	sicia	an	1		Medica	.1
put	should be filed within and Mental Hygiana. marked other than amatic avent, tre M	Be	17. Fether's Name (First, Middle, Las								e, Meiden Sumeme)	
7	should nd Men merke ametic	2	John William St			100 100		404	Mae Ke		to Oh o To Oh	to Zio Codel
Maryland	d 2 sho h and 7 is me traum		19a. Informent's Name/Reletionship								ber, City or Town, Ste	20852-2937
	1 end 2 Health em 27 i		Mary Stohlman (Wi 20a. Mathod of Disposition	re)	20b. I	Pleca of Disp cemetery, cre				Dete Dete	20c. Location - Cit	
Baltimore,	permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiena. Important: If item 27 is merked other than any injury or other traumatic avent, the Meonce.		1 ☑ Buriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec		8					0/0/00		
=	nit. F ortan injur		21. Signeture of Funeral Servica Llc	-	Gai						neral Home	ring, Maryland
B	Depar Impor		> Michael L) Aibb	ons	10 G.	0 Eas	st De	er Park	Drive 0877		
П	A 11		23a. Pert1. Inter the disease, or co shock, or haert failure. List on	mplications that ceus ly ona ceuse on eech	ed the deet line.	th. Do not er	nter the m	ode of dyi	ng, such es cerdi	ac or respiretory	errest,	Approximata Intervel Between Onset end Deeth
	Physician /Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in deeth)	B	adde	1 can	cer					2 years
		ner	resulting in deetily		Due to (or as a conse	iquanca c	f):				J
,00	tificate be executed g physician end es the bunal-transit	edical Examiner	Sequantially list conditions, if eny, leading to immediata cause. Enter Underlying	b	Due to (or es e conse	oquenca o	f):	Test 8			
x 68760,	ertificate b ling physic le es the b		Causa (Disease or injury that initiated evants resulting in deeth) Lest	c	Due to (d	or es a conse	quence o	f):		30 (00)		
Box	death cer e ettendir ed for use	lan										
o.	he de	Physician/M	Pert II. Other eignificant conditions	contributing to death	but not res	sulting In the	underlying	g cause gi	ven in Pert I.			bute to the cause of death?
۵.	ned by									- 11	Yes 2□No 3	Probably 4/2 Unknown
Records,	law requiras that the death cer has been signed by the ettendin s 2 should be detached for use	Completed by				· · · · · · · · · · · · · · · · · · ·			FPL	24e. We per	es en eutopsy formed?	24b. Were eutopsy findings aveilable prior to completion of ceuse of daeth?
m m	Tha law ate has page 2	E O								10	Yes 22 No	1□Yes 2☑No
/ita	cartificate rector, pag	Be	25. Was casa rafarrad to medical examiner?						26. Plece of D	eeth (Check only	one)	
of Vital	g Physiclan: er this cartific eral director,	2	1 ☐ Yes 2 ☐ No 27 Manner of Daath	Hospitat: 1 ☐ Inpa 28a. Data of In	jury	ER/Outpatie		DOA Ot			sidence 6 Other	
ion	Attending ir death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigati	(Month, E	ey rear	Injury	М		Yes 2 □ No			
Division	D aff o	Certification:	3 Suicide 6 Could not determine	d 286. Pieca of I	njury - At h etc. <i>(Speci</i>	ome, farm, s	treet, fect	ory, office			(Street end Number own, Stete)	or Rural Routa Number,
	To the Hospital within 24 hours or the Funeral completaly filled	edical			of examina						e ceuse(s) and mann a, dete end pleca, end	
	Withir To th	Me	29b. Signature and title-of certifier		11111		2	29c. Licen	se number		29d. Date signed (I	
	15		1 Hall	00	wo	1		D4	5880		9/4/9	8
			30. Nama and address of person wh	o completed causa of	deeth (Iter	n 23e) (Type	, Print)		- 550			
			Leon Hwang, M.D.	10400 Cor	nect	Lcut Av	enue	#60	6, Kensi	ngton, N	D 20895	
	Sta Registra		31. Dete filed (Month, Day, Year) SEP 0 8 10		trar's Sign	eture 4	1	boux	61			



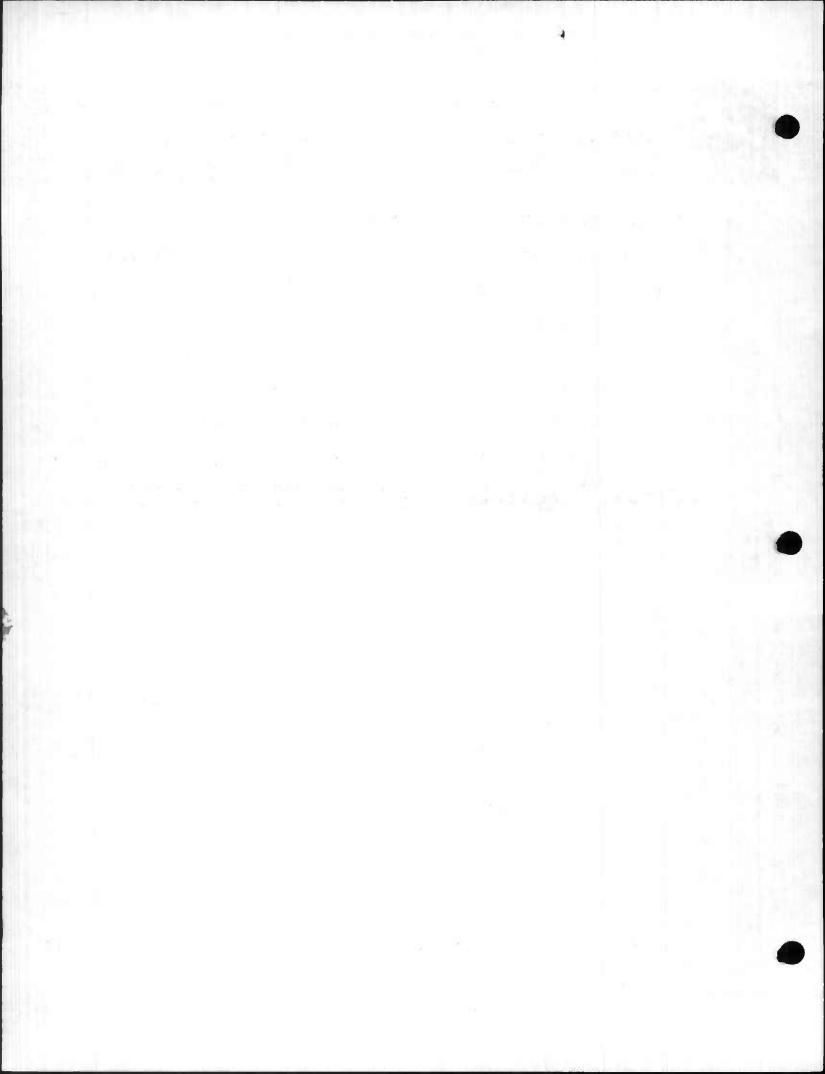
State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of	Death		Reg. No.	6.2001	
Dharatatan	1. Decedent's Neme (First, Middle, La	st)		W DO	Mari D	2. Date of De Month		3. Time of Dea	
Physician /Medical	EDNA	SUSM	AN			SEPT.	6, 19	98 4:25	
Examiner	4a Fecility Name (If not Institution, give	e street and number)			4b. City, Tow	n, or Location of Deat	4c. County of	Deeth	
	7200 DELFIEI	D ST.			CHEVY		MON	TGOMERY	
Funeral Director	3/3-20-1315	ex 7. Age (In ye	rs. last birthday Yrs.	Months Days	If Under 2	Min. 8. Date of Bir (Month, Da AUG • 2	y, Year)	Birthplace (State or For Country) MICHIGAN	
1	Usuel Residence of Decedent 10a. State 10b. County	10c	City, Town or L	ocation				10d. Inside City Li	
or 28s-faho be noured Director	MD. MONIGO			HEVY CHAS	E			1 ∑ Yes 2 □	
Sa or 2 at being	10e. Street and Number 7200 DELFT	ELD ST.		10f. Zip Code	815		10g. Citizen of What Country? U. S. A.		
ena. than "natural", or items 23a or 28a-f ahow he Madical Examiner must be notified at ompleted by Funeral Director	11. Merital Status 1 Never Merried 2 Merrled 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:	U,S. 13.		lispanic Origi	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race -	American Indian, White, etc.	
yglene. for then "natural", it, me weden Ex- Completed by	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usuel Occup kind of work done	during most a	of working	16b. Kind of Busi	ness/industry	
then the Men	Elementary/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use retire HOMEMAKE			AT	HOME	
To be 84	17. Fether's Neme (First, Middle, Last)			110411411111	_	s Name (First, Middle		1108-43	
ed other	FRANK	HARTMAN				BLANCHE	E.	BELL	
and Mental le marked or aumetic ever			40h 14c1	ion Addrona (Cto	and Alumb	or Rural Route Numb			
5 2 2	19a. Informent's Neme/Relationship (I	N /husband	3	SAME AS	ITEM	#10			
Department of Heal mportant: If item 2 any injury or other ance.	20e. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removel from State	cemetery, cre	osition (Name of emetory or other ple RS CREMAT		9/8/98	20c. Location - Ci	LE, MD.	
e attending physician and with a stranging and with	shock, or heart feilure. List only Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last	e. PANCREZ Due to b. Due to	ATIC C (or es e conse	quence of):				Interval Betweer Onset and Deat	
d by the attending stached for use a Physician/M	Pert II. Other significant conditions of	d	esulting in the	underlying cause gi	ven in Part I.		118-211-221-221	ibute to the cause of de	
s been sign 2 should be pleted by							an autopsy ormed?	24b. Were autopsy findir available prior to completion of cause of death?	
page Com						10	Yes 2 No	1 ☐ Yes 2 ☐ No	
i i	25. Wes case referred to medical examiner?			,		of Death (Check only	one)		
0 0 E	1 ☐ Yes 2 No		☐ ER/Outpatie	INT SEL DON		sing Home 5 X Resi			
eath. or: After ti he funera	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			M 1	ryat rk? ∣Yes 2⊡N	0	how injury occurred Street and Number	or Rural Route Number,	
	4 Homicide determined	building, etc. (Spe	cify)		9 112	City or To	wn, Stete)		
in 24 hours he Funeral pletaly filled edical C	29a. Certifier 1\(\sume2\) Certifying Ph (Check only one) 2 Medical Exam	yelclan: To the best of my k ilner: On the basis of exami end menner steted.	nowledge, deal nation and/or in	th occurred at the ti nvestigation, in my	me, date and opinion, death	place, and due to the occurred at the time,	cause(s) and man date and place, an	ner as stated. d due to the cause(s)	
within 2 To the comple	29b. Signature and little of certifier	10-	٨	29c. Licen	se number		29d. Date signed	(Month, Day, Year)	
0	1 Kobut t	+Blee M	N		3556		SEPT.	8, 1998	
	30. Name and address of person who a				IN AV	E.,SUITE	1400.CH	HEVY CHASE	
State	31. Date filed (Month, Day, Year) SEP 0 9 199	32 Paraistrar's Sig		Spark				2081	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 4, 1998 **Physician** BELLA SABRIN 8:01 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 7. Age (In yrs. last birthday) | ff Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) MAY 27, 1920 Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Yrs. 78 RUMANIA Director 098-38-5998 Usual Residence of Decedent the Maryland r 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò the Medical Examiner must be 20901 'natural', or items 23a 606 CONCERTO LANE UNITED STATES permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Montal Hygiens. Important: If then 27 is marked other two-gents. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE P 3 ₩ Widowed 4 Divorcad 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) WOLF MEERBAUM SARA KATZ 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD SABRIN (SON) 624 CONCERTO LANE - SILVER SPRING, MARYLAND 20901 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ R 4 Donation 5 Other (Specify) MT. HEBRON CEMETERY 9/6/98 FLUSHING, NEW YORK 22. Name and Address of Facility
DANZANSKY—COLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical metastatic Sweast cancer Examiner Due to (or es e consequence ot): Examiner The law requires that the death certificate be executed physician and s the buriel-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Psendomonas sepsis by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? malignant plemal effusion 1 Yes 2 No 1 ☐ Yes 2 ☐ No e Hospital or Attending Physician: 124 hours after death. • Funeral Director: After this certifical letely filled in by the funeral director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturaf 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a, Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a Sofor MO D43083 September 05, 1998 5 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Dive # 300 Rodeville, MD 20850. 9707 Medical Center 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State SEP 08 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene 9 8 2000 2

SEPTEMBER 04, 1998

ADDIEN C.	SKUREPA			Certifica	ite of	Death		Reg. N	No.		000
Physician	Decedent's Neme (First, Middle, L ALLEN		is si	COREPA			Mont	of Deeth h [ову 03,	Yeer 1998	3. Time of Death 1120AM
/Medical Examiner	4a Facility Neme (If not institution, gr			.01		4b. City, Town,			4c. County	-	1120111
LAMITIME	16 DUKE STREET S	HTTI				ROCKVII	J.E	1	MONTG	OMERY	COUNTY
Funeral	5. Sociei Security Number 6.	Sex 7. Age	(In yrs. lest birt		ler 1 Year	If Under 24 h		of Birth			ce (Stete or Foraign
Director	334-34-9922	10XM 2□ F	57	Yrs. Month	s Deys	Hours N	AUG.	25,1	941	ILL	INOIS
2	Usual Rasidence of Decedent									1	
72 hours after death with the Maryland natural;, or items 23s or 23s-1 show disal Examinar must be notified at steed by Funeral Director	10a. State 10b. County		10c. City, Towr	or Location						100	d. Inside City Limits
o Me	MD. MONTGO	MERY		ROCKVI	LIE						1) Yes 2□No
or 22	10e. Street end Number			10f. 2	Zip Coda			10g. (Citizen of V	What Country	y?
r here 23e or 28e-f sinner must be notified.	16 DUKE S	T. SOUTH			208					J.S.A.	
E S	11. Marital Status	12. Wes Decedent E Armed Forcas?	ver in U,S.	13. Wes Dec	edent of F becity Cub	Ilspenic Origin? an, Maxicen, Pu	(Specify Yes larto Rican, at	or No- c.)		a - Americei ck, White, at	
N. F.	Never Married 2 ☐ Married	1 ☐ Yes 2 📉 Ne If Yes, Giva	0	1 ☐ Yas	2)() No	Specify:			Specify	<i>r</i> :	
d by	3 Widowed 4 Divorced	Yaer or Dates:								WHI	
Department of results and whether trygener. Department: If then 27 is marked other than "natural;, or items 23a or 28a-f show many injury or other traumatic event, the lead call Examiner must be notified at once. To Be Completed by Funeral Director	15. Decedent's E (Specify only highast g	ducation rede completed)	169.	Decedent's Us (Give kind of the property)	vork dona	duning most of	working	16b.	Kind of Bu	usiness/indu	stry
ther than and, the Me	Elementery/Secondery (0-12)	College (1-4or 5-	+)	lifa. DO NOT					DI	CIDATES	A DITT
Co	17 Eathada Nama (First Addust)	5+		FOOD	SER		Name /Eins 4	Aiddle Afric		STAUR	ANT
Be ver	17. Fether's Neme (First, Middle, Las					TO. MOTHER'S	Name (First, A				
5 5 C	CHARLES	SKOREPA					BERNI		MAF		
E E	19e. Informent's Neme/Reletionship					end Number of					(ode)
n 27		REPA/MOTHER				r, BROOM					
f item 27 or other tr	20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3	Removel from Stata	20b. Place of cameter	Disposition (A y, cremetory o	r othar ple	ce)	Dete	20c.	Location -	City or Tow	n, Stete
ury o	4 ☐ Donetion 5 ☐ Other (Spec		CHAI	MBERS C	REMA	PORY	19/5/9	8	RIVEF	RDALE,	MD.
vsician	23a. Part 1. Enter the disease, or cor shock, or heart failure. List onl	nplications that caused y one causa on eech lin	MOOO91 tha daath. Do r	CHAME	ERS]	FUNERAL ng, such es cen	HOMES diac or raspire	P.A.,	RIVE	1	MD. 2073 Approximete Intervel Between Onsat and Deeth
edical miner	Immediate Ceuse (Final disease or condition resulting in deeth)	o. Hyperte	Oue to (or es e	ather consequence of	5c)ze	notic C	Dis	vasio	alar		
s the buriel-transit	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disaasa or injury that initiated evants	b	Dua to (or es e o	consequence o	f):						
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hed hed	Pert II. Other significant conditions	contributing to deeth bu	t not resulting in	the underlying	g cause gi	ven in Pert I.	23b	. Did tobac	co uss co	ntributs to 1	the cause of death?
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cate has been signer, page 2 should be d								. Wes en au performad	?	avai	re eutopsy findings ilabla prior to aplation of ceuse
S S O							12	mitee	_		eeth?
director, page	or III							1 2 Yas	2 LI NO	112	Yas 2□ No
rector, pag	25. Was cese refarred to medicel exeminer?	Hospitel:			Or	her	Deeth (Check				
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al Director: After the funers of in by the funers Certification:	2 Accident Investigati 3 Suicida 6 Could not 4 Homicide datarmine	be Ope Bloom of Inju	ry - At home, fa . (Specify)				28f. Loca City	ation (Street or Town, St	t and Numl tata)	ber or Rural	Routa Number,
Funer eteky fill dicai	29a. Certifier (Check only one) 1☐ Cartifying P 2 Medical Exa	hysician: To the best of miner; On the basis of and mannar stel	axamination en	, daath occurre d/or investigeti	ed et the ti	me, data end poplnion, daeth o	ece, end dua eccurred et tha	to the ceuse time, date	a(s) end me end plece,	enner as sta end dua to	ited. the ceuse(s)
Me th	29b Signature and title of certifier				29c. Licen	se number		29d.	Date signe	d (Month, D	Jev. Year)

State Registrar

Atiphen S. Radentz 31. Date filed (Month, Dey, Yeer) 32. Regist SEP 0 8 1998

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

- 10. The state of the last -cu all c (315)

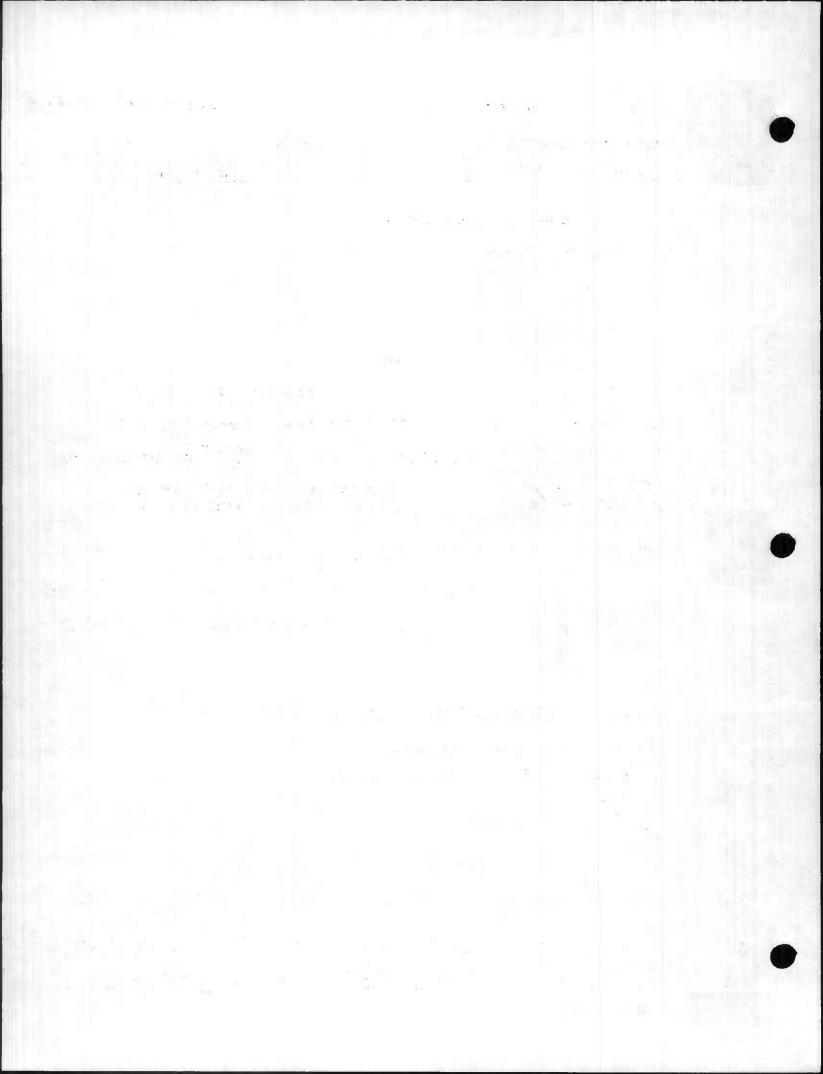
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death **Physician** AUGUST 30,1998 15:40 PM SHOCKEY **JAMES** SR. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner Allegany Sacred Heart Hospital Cumberland If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 X M 2□ F Months Deys Yrs. Director 216-05-5307 Usuel Residence of Decedent 93 April 12,1905 MD with the Marylenc 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Madical Examinal must be notified at 1 ☐ Yes 2 No MD **Allegany** Lonaconing Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21314 Charlestown RD S.W. 21539 USA pemit. Peges 1 and 2 should be filed within 72 hours effer death v Department of Heelth and Mental Hydiene. Important: If Itam 27 is marked other than "natural", or items 23a empt holyry or other traumatic event, the Medical Examinet mans. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: altimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 Labor Coa1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Drusilla Dye William Shockey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Calvin Shockey Son 17205 Jackson Run RD, Lonaconing, MD 21539 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State Sept. 2 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Mt. View Cemetery Moscow Mills, MD 4 □ Donation 5 □ Other (Specify) 1998 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses Eichhorn-McKenzie Funeral Home P.A. 8 E. Main Street, Lonaconing, MD 21539

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** Examiner maestive ician end buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): attending physician for use es the bune Physician/Medical 23b. Did tobacco usa contribute to the ceuse of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. the 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was en autopsy performed? completion of cause of death? to lung Chronic 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to examiner? or Attanding Physician: funerel director, Be medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 2 1 Dinpatient 2 ER/Outpetient 3 DOA this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 Tes 2 No 24 hours after death. 2 Accident 6 Could not be determined 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner es stated. Medicai 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) To the F within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AUGUST 3/ 1998 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Si Kander L. Sandhir MD:

31. Date filed (Month, Day, Year)

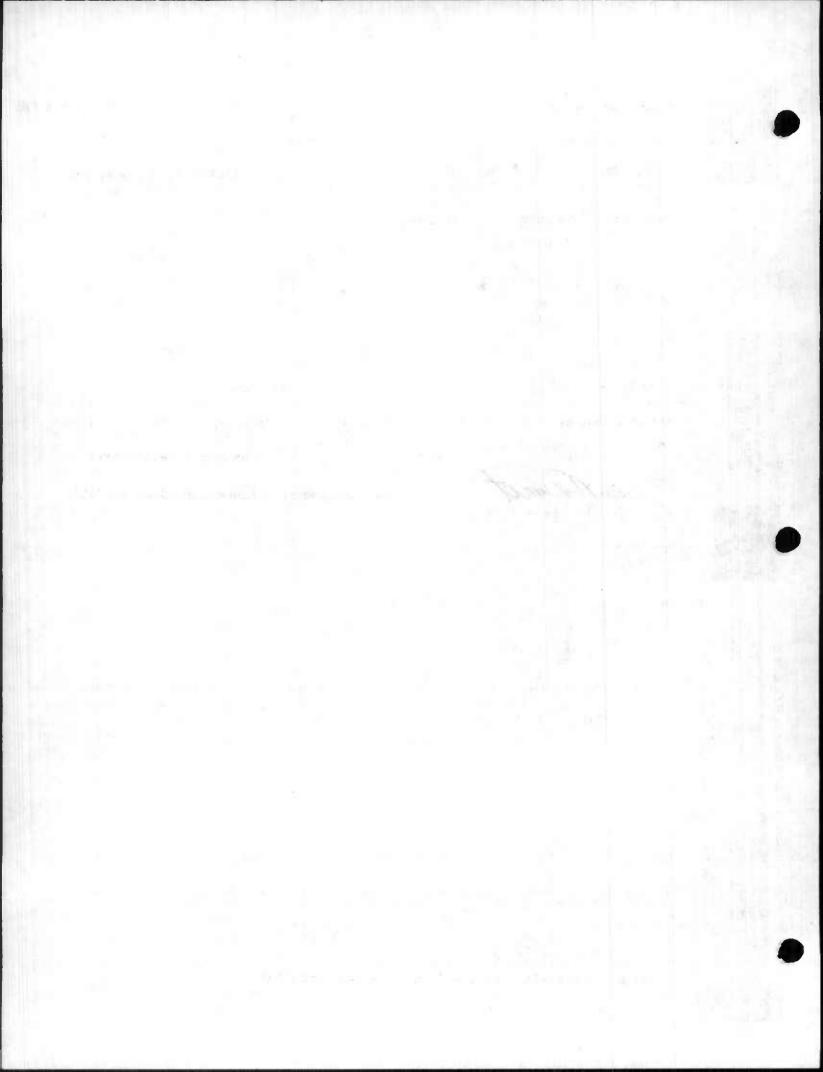
SEP 0 8 1998

32. Registrer's Signature 4265 48 Tarn Terrace State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 9 9 9 9 5

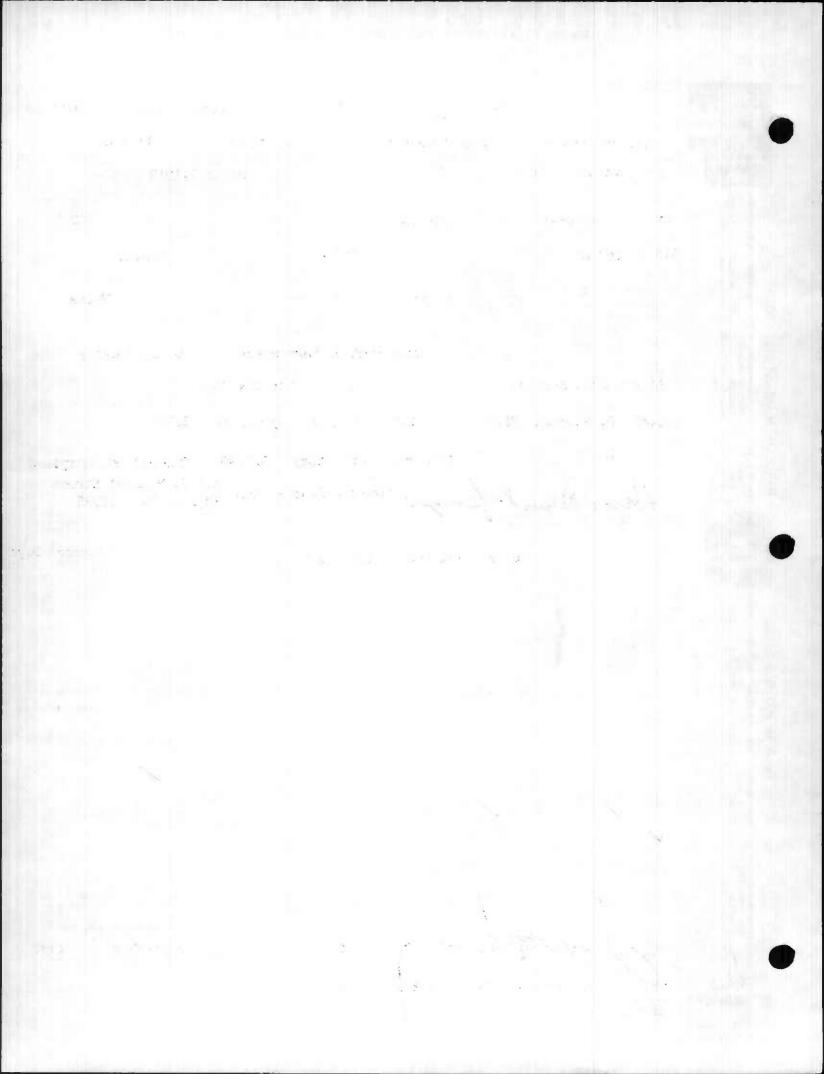
		Decedent's Name (First, Middle, L.	and)		C	ertific	ate of	Death		Reg. No.	9 6	9093
Physici	ian								2. Date of D Month	Day	Year	3. Time of Deeth
/Medic		Effie Lillian Shock 4a. Facility Name (If not institution, gi		harl				4h City Tours	Septer or Location of Dea		9 1998	10:00PM
Examir	ner	The second secon	ve sheet end nam.	761)					or Location of Dec		nty of Death Allegan	V
, Funeral		2668 Finzel Road 5. Social Security Number 6.	Sex 7	Age (In vn	s. last birthd	av) If Un	der 1 Year	Finzel If Under 24 H	frs. 8. Date of B			•
Director		214-07-3086 Usual Residence of Decedent	1□M 2以F	80	Yrs	Monti	hs Days	Hours M	lin. 8. Date of B (Month, L			place (State or Foreign etry) yland
dand w		10a. State 10b. County		10c. C	ity, Town o	Location					1	0d. Inside City Limits
Mary	to	Maryland Alle	egany	Fr	ostburg							1 ☐ Yes 2 ☑ No
r 28s	Funeral Director	10e. Street end Number		11	0310018		Zip Code			10g. Citizen	of Whet Cour	ntry?
38 o	0	2668 F	inzel Road				214	532-			S.A.	
ms 2	ner	11. Merital Status	12. Was Deced	ent Ever in	U,S. 1	3. Was De			(Specify Yes or Nerto Rican, etc.)		Raca - Americ	an Indian,
72 hours after deeth with the Maryland neturel, or Items 23e or 28e-f show ore Examiner must be notified at	by	1 ☐ Never Merried 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	Armed Forc 1 Tes 2 If Yes, Give Yeer or Date	No No			specify Cub s 2 12 No	Specify:	erto Rican, etc.)		Black, White, cify: Whit	
d within 72 hours af giene. ir then "neturel", or ire Med cal Every	ted	15. Decedent's E			16a. De	cedent's U	sual Occu	pation		16b. Kind o	Business/Inc	dustry
s 1 and 2 should be filed within 72 hc f Health end Mental Hygiene. Item 27 is marked other then "netur other traumatic event, ma Medical	Completed	(Specify only highest gr Elementery/Secondery (0-12)	College (1-4	or 5+)	- (G	e. DO NO	work done T use retire	during most of (working			
d wigien	Son	6	0		Car	egiver				Nursing	Home	
d 2 should be filed within h end Mental Hygiene. 7 is marked other than " traumatic event, me Mer	Be	17. Fether's Name (First, Middle, Las	t)					18. Mother's N	Name (First, Middle	e, Meiden Sum	ame)	
Ment Ment rked rice	10	John Werner						Rose	e Finzel			
d 2 should be file th end Mental Hy 7 is marked othe traumatic event.		19a. Informant's Name/Relationship	(Type, Print)		19b. M	ailing Addr	ess (Stree	and Number or	Rural Route Num	ber, City or To	vn, Stete, Zip	Code)
of Health Item 27 i		Bonnie G. Shockey		aughte	r 266	8 Finzel	Road		Frostbura	Mo	aryland	21532-
emit. Peges 1 a Separtment of Hes mportant: If Item iny Injury or othe ince.		20a. Method of Disposition	70		Place of Di cemetery,	sposition (/	Name of or other pla	ce)	Date	20c. Location	n - City or To	wn, State
Peges nent of 8 int: if ite		1 Burial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Speci			zei Cen				12-Sep-98	Finzel,	Marylai	nd
permit. Peges Department of Important: If I any Injury or once.		21. Signature of Funeral Service Lich	nogo /	_			and Addre	ess of Facility				
00 = e d		John 14	uerry			Durst	Funer	al Home, 5	57 Frost Ave	e., Frostbu	ırg, MD	21532
		23a Fert1. Enter the diseese, or conshock, or heart failure. List only	nplicetions that cau	sed the dea	ath. Do not	enter the m	node of dyl	ng, such as card	llac or respiratory	arrest,	1	Approximate Interval Between
Physician											- 1	Onset end Death
/Medical Examiner		Immediate Cause (Final disease or condition e. Mulanma luphagus resulting in deeth)										
Exammer		resulting in deeth)	0.	Due to	or as a con	sequence o	of):	Y				1
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and trans	Examiner	Sequentially list conditions.	D	Due to	or as a con	sequence o	of):					
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icete be executed physician and s the burial-transit	Medicai	that Initiated events resulting in death) Last	C	Due to (or as a cons	sequence o	of):					
leath certifica attending pl											!	
ath o ttènd or us	Physician/		0.									
s der	ISIC	Part II. Other significant conditions of	contributing to deat	h but not re	sulting in the	e underlyin	g cause gir	ven in Part I.	23b. Dic	tobacco use	contribute to	the cause of death?
law requires that the death certificate be executed es been signed by the attending physician and a 2 should be deteched for use as the burial-transit	by Phy	- Hypert	genesia						1	Yes 2 KN	3 □ Prot	bably 4 Unknown
n sig		N 1-	0						24a. Wa:	s an autopsy	24b. We	ere autopsy findings
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D age	6	1 Avetural 5 ☐ Pending	28a. Dete of I (Month,	Day Year)	28b. Time Injur	У	28c. Injui		28d. Describe	how Injury occ	benus	
tor: the	cat	2 Accident Investigatio				М		Yes 2 □ No				
a or Attendir s after death. I Director: Al	Certification:	4 ☐ Homicide determined	286. Place of	etc. (Spec		street, fact	ory, offica			(Street and Nu wn, Stete)	mber or Rure	l Route Number,
Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune		One Contiller ATT CONTACT OF						- 5000 100				
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nyalcian: To the be miner: On the basis	s of examina	owledge, de ation end/or	ath occurre Investigati	ed at the tir on, In my o	ne, date and pla pinion, death oc	ce, end due to the curred at the time	cause(s) end date and plac	manner as stee, and due to	eted. the cause(s)
athin a	Me	29b. Signature and title of certifier	and manner	stated.								
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2		A	Bry	/FV)			U	12376		7-	11-9	r
MILL		30. Name and address of person who										
/// A	1				_							
rus		George M. Brezd, 31. Date filed (Month, Day, Year)		Drive, strar's Sign		erland	, Mary	land 2150	2			



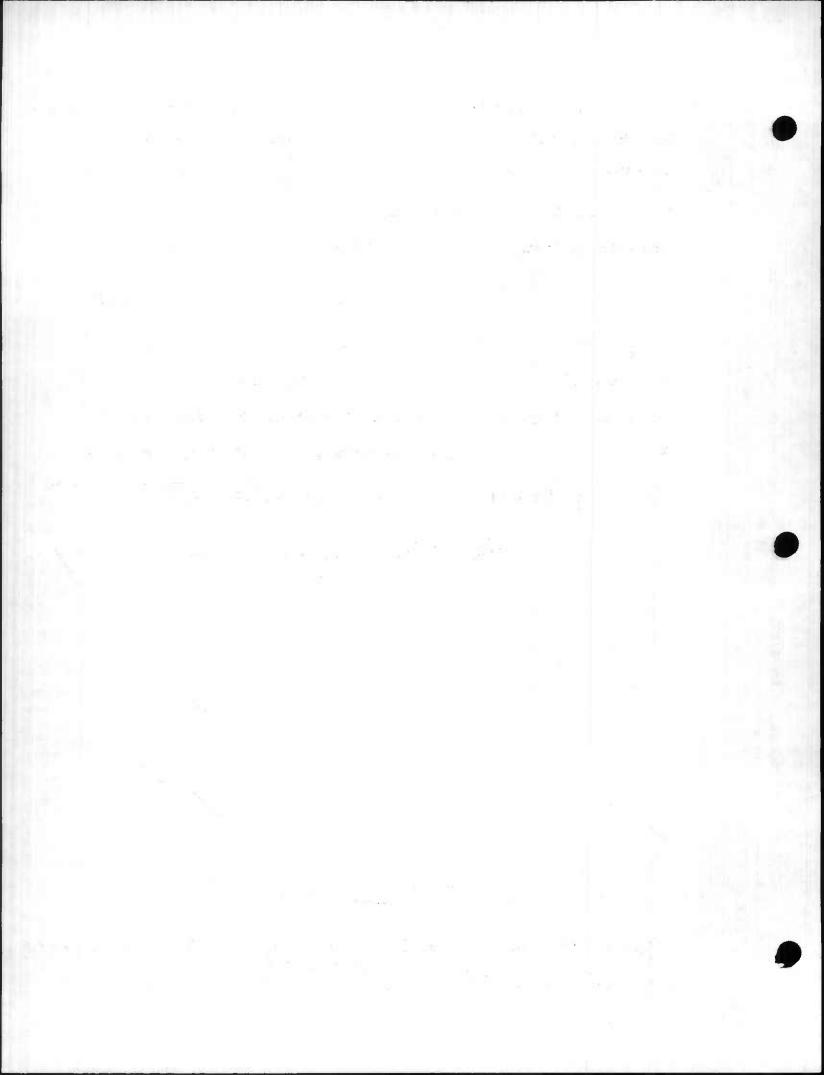
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State of Maryland / Department of Health and Mental Hygiene 2 9 0 9 6

				Cert	ificat	e of L	Death		R	eg. No.			
	1. Decedent's Name (First, Middle, Las	t)						2	Dete of Dee Month	th Dev	Yeer	3. Time o	of Death
Physician /Modical		JOHN	Pau1		STE	EPHEN		S		er 4,19		4:0	5 pm
/Medical Examiner	4e Fecility Neme (If not institution, give	street end number)	Faul		- 4	4	b. City, Tov		tion of Deeth	4c. County			
	Memorial Hospit	al & Medi	cal Cer	ter			Cumb	erlar	ıd	Alle	gany		
Funeral Director	5. Social Security Number 6. Security Number 217-10-1646	ox 7. Age	(In yrs. lest bi	rthday) _ Yrs.	If Unde Months	1 Year Deys	If Under a	Min.	Date of Birth (Month, Dey arch 7	Year)	9. Birthpl Count Ohic		or Foreigi
>	Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Tov	m or Loo	ation						14	Od. Inside C	The Limite
or 28a-f show per notified at Director					ation						1		s 2 No
Pecto Pecto	WV Mineral		Keys	er	101 7:	0-4-				On Citizen of H	What Cours	Λ	
r items 23s or 28s-f s riper must be notified Funeral Director	10e. Street end Number 215 D Street					6726				0g. Citizen of V	Α.		
0 = -	11. Maritel Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 1 Types 2 □ N If Yes, Give Year or Dates:	Terror Vision	81	/as Dece Yes, spe □ Yes	city Cuba	ispenic Orig n, Mexican Specify:	gin? (Specil , Puerto Rid	y Yes or No- an, etc.)		e - America k, White, e Wh		
ted	15. Decadent's Ed	ucation	16e	Decede	ent's Usu	al Occupi	etion	of warking		16b. Kind of Bu	siness/Ind	lustry	
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arked of arked To B	Albert John Ste	phen					Luci	retia	tia Pugh				
and Mental Is merked or aumetic eve To Be	19a. Informent's Neme/Reletionship (7	ype, Print)	19	b. Mailing	Addres	s (Street	and Numbe	or or Rurel F	Route Numbe	r, City or Town,	Stete, Zip	Code)	
27 is 27 is r trat	Dorothy D. Stephen	n (Wife)		215 1	D S	tree	t, Ker	yser,	WV :	26726			
r Haalth tem 27 other tr	20a. Method of Disposition		20b. Plece C	of Dispos	ition (Na	me of other place	a)		Dete	20c. Location -	City or To	wn, Stete	
Department of Haalth moortant: If Item 27 my Injury or other to	1 ☐ Burial 2 🏋 Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify		Cumbe					9/5/	98	Cumber1	and,	Mary1	Land
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by the ached	Pert II. Other significent conditions co	entributing to deeth bu	t not resulting	in the un	derlying	cause giv	en in Pert I	•		obecco use co			
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has je 2 mp									1 🗆 Y	es 2 No		deeth?	□No
certificate rector, pag	25. Wes case referred to medical exeminer?						26. Plece	of Deeth (Check only o	ne)			
	1 Ves 2 No	Hospitel: 1 Inpatie	nt 2 EP/O	utpatient	3□ D	OA Oth	er: 4 🗆 Nu	rsing Home	5 Resid	ence 8 🗆 Oth	er (Specif	y)	
h. After ti funera funera	27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28e. Dete of Injur (Month, Dey	Year) 28b.	Time of Injury	м	28c. Injur Wor	y et k? Yes 2□	-	d. Describe h	ow Injury occur	red		
within 24 hours after death. To the Funeral Director: Affert completaly filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injubuilding, etc	ry - At home, f . (Specify)	erm, stre	et, fector	y, offica		28	f. Location (S City or Tow	itreet e <i>nd N</i> umb n, Stete)	er or Rure	l Route Nu	mber,
Euner Funer staly fill		reician: To the best of iner: On the bests of end manner ste	examination e										(s)
To the comple	29b. Signature and title of cartifier	1			29	c. Licens	e number			29d. Date signe	d (Month,	Dey, Year)	
10	A AS	Of		1		D 07	164			Septemb	er (9 1	998
	30. Name and address of person who o	completed cause of de	eath (Item 23e)	(Type, P	Print)								
MS	Dr. Jack Harvey-	Seton Dri	ve-Cumb	er1=	and.	MD 2	1502						



		11		iale 0	i waiyia		ertificate of		i wentai m	Reg. No.	8 2	9097
Physic /Medi		1. Decedent's Name (First, Midd Lillia		Schme	eizl				2. Date of D Month Sept.	Day	Year 8	3. Time of Death 12:25 am
Exami		4a. Facility Name (If not institution 1805A Vincenz			m <i>ber)</i>			4b. City, Town, Elders	or Location of Dea		onty of Deeth	
Funeral Director		5. Social Security Number 219–14–0834	6. Sex 1 ☐ M		7. Age (In yrs 78	. lest birthday Yrs.	Months Days	If Under 24 H Hours M	in. 8. Date of B	irth 1920	9. Birth	place (Stete or Foreign ntry)
haryland show	or.	Usual Residence of Decedent 10a. State 10b. Count MD Carro			10c. C El	ily, Town or l dersbu	ocation					10d. Inside City Limits 1 ☐ Yes 2√7 No
with the h	Funeral Director	10e. Street and Number 1805A Vincenza	Drive	2			10f. Zip Code 21784			10g. Citizen USA	of What Cou	**
Iore, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health end Mental Hygiene. If item 27 is merked other than "natural", or items 23a or 28a-f show or other traumetic event, the Medical Event natural to notified at	by Funera	11. Marital Stalus 1 □ Navar Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	rried	Was Dece Armed Fo I Yes If Yas, Giv Year or Do	2 No	J,S. 13	Was Decedent of I If Yes, specify Cub	dispante Origin? an, Mexicen, Pu Specify:	(Specify Yes or N arto Rican, etc.)		Race - Aman Black, White, ecity: Whi	etc.
id 21215-0020 filed within 72 hours af Hygiene "natural", or ort, the Medical Exem-	Completed	15. Decede (Specify only high: Elementary/Secondary (0-12)	1		-4or 5+)		edent's Usual Occup e kind of work done DO NOT use retire eat wrapp		working	16b. Kind o	of Business/In	dustry
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in Pe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Olher (-		oval from 3	State La	Place of Disp cemetery, cric Ke Vie	osition (Neme of emetory or other ple W Cemeter	y Y	9-4-98		on - City or To	
Baltimo permit. Peg Department Important: It any Injury o		21. Signatura of Funeral Services Paige Hargh	- 1	bert			22. Name and Address. O. Box 1		Haight F			& Chapel
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68760, ficate be executed physician end st the buriel-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury	f b. —		Due to	or as a conse	equence of):					
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- 0 0 8	Physician/M	Part II. Other algnificant condit	ons contribu	iting to de	eath but not re	sulting In the	underlying ceuse gi	/en In Part I.	23b. Dfc	i tobacco use	contribute t	o the cause of death?
P het the delection delect	by Phy								15	Yes 2 N	lo 3□Pro	bably 4 Unknown
aw requir	Completed t									s an autopsy formed?	av	ere autopsy findings vailable prior to empletion of ceusa death?
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of Vital Physician: Tithis certificate ral director, pe	To Be	25. Was case referred to medice exeminer? 1 Yes 2 No	Hosp	ital:	npatient 2	☐ ER/Outpatie	ent 3 DOA Oth	or.	Deeth (Check only Homa 5 D Ras		Other (Specia	(v)
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r Attender ter death	Certification:	2 Accident Invest 3 Suicide 6 Could 4 Homicide	not ba nined 2	Be. Place buildin	of Injury - Af I	nome, farm, s	M 1 □	Yes 2□No		(Street end No own, Stete)	um <i>ber</i> or Run	al Route Number,
To the Hospital or within 24 hours aff To the Funeral Di completely filled in	edicai C	29a. Certifier (Check only one) 1 Certifyl 2 Medical	Examiner:	On tha ba	best of my kn isis of examin ner stated.	owledge, dea ation and/or li	th occurred at the tinvestigation, in my o	me, date and pla pinion, deeth o	ice, and due to the courred at the time	e cause(s) and , date and pla	I manner as s ce, and due t	stated. o the cause(s)
To the Vithir To the comp	Me	29b. Signalura and title of certific		Lev	me,	M.D.	29c. Licens D17	e numbar 873.		Sal	gned (Month,	Dey, Year) 2, 1998
		30. Name and address of person	Cour	ted ceus	e of death (Ite	m 23a) (Type Su	Peint) Mars	hall A.L	Himore	, MI) 2/	1208
Sta Registr		31. Date filed (Month, Day, Yeer SFP 0			eglstrer's Sign	ature	4. Spar	K		/		

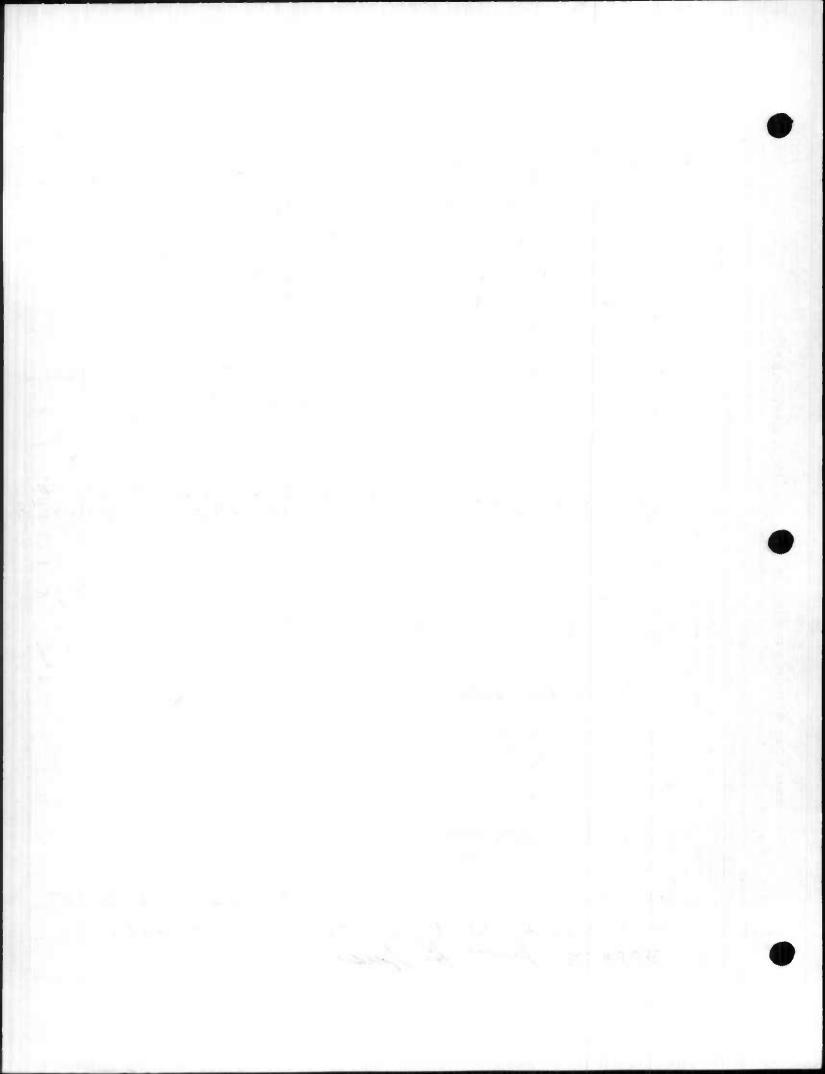


TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to bruial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Inlury, or other traumatic event, the medical examiner must he marked.

	1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.
	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF OEATH
1	John treston Snider St 8 3 96 044
	4, SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 8. AGE (In yrs. lest birthday) IF UNDER 14 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1 M 2 F 75 YRS. WONTHS DAYS HOURS MIN. WAR 10, 1923 8. BIRTHPLACE (State or Foreign Country) M D
2	96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH
100	RESIDENCE OF DECEDENT
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY LIMITS?
	10 STREET AND MINNESS
FUNERAL	3 West Todd Slope 21048 109. CITIZEN OF WHAT COUNTRY?
BY	11. MARITAL STATUS 1
ETED	15. DECEDENT'S EDUCATION 168. DECEDENT'S USUAL OCCUPATION 166. KIND OF BUSINESS MADDISTRY
	Elementary/Secondary (0-12) College (1-4 or 5+)
COMPL	745 0 CArpenter Local 101
Ш	Preston S. Snider (First, Middle, Melden Surneme) To A Mills
0	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2	Mrs June Snider (wife) 3 W. Todd Slope Finksburg MD 21048
	20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Square Property, cramatory or other place) 20c. LOCATION — City or Town, State
	4 Donation 6 Other (Specify) Evergreen Mausoleum 9/3 Finksburg MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE PRINTS PUNERAL HAME Chapel PA
	23. PART Center the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate
CERTIFICATION	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): C. OUE TO (OR AS A CONSEQUENCE OF): Approximate Initiated of Vision and Consequence of the initiation of Vision and Consequence of Vision and Cons
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL
SICI	EXAMINER? HOSPITAL: OTHER:
H	27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCUPED
ВУР	1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO
	3 Suicide 4 Homicide Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated, one) 2 MEDICAL EXAMINER: On the best of axemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)
10 B	John Mildut
	Lot Poble (In Wistrownly MA 21157
	31. DATE FILED (Month, Day, Year) 32. DEGISTRAR'S SIGNATURE
	SEP 0 8 1998 Serve B. Spark

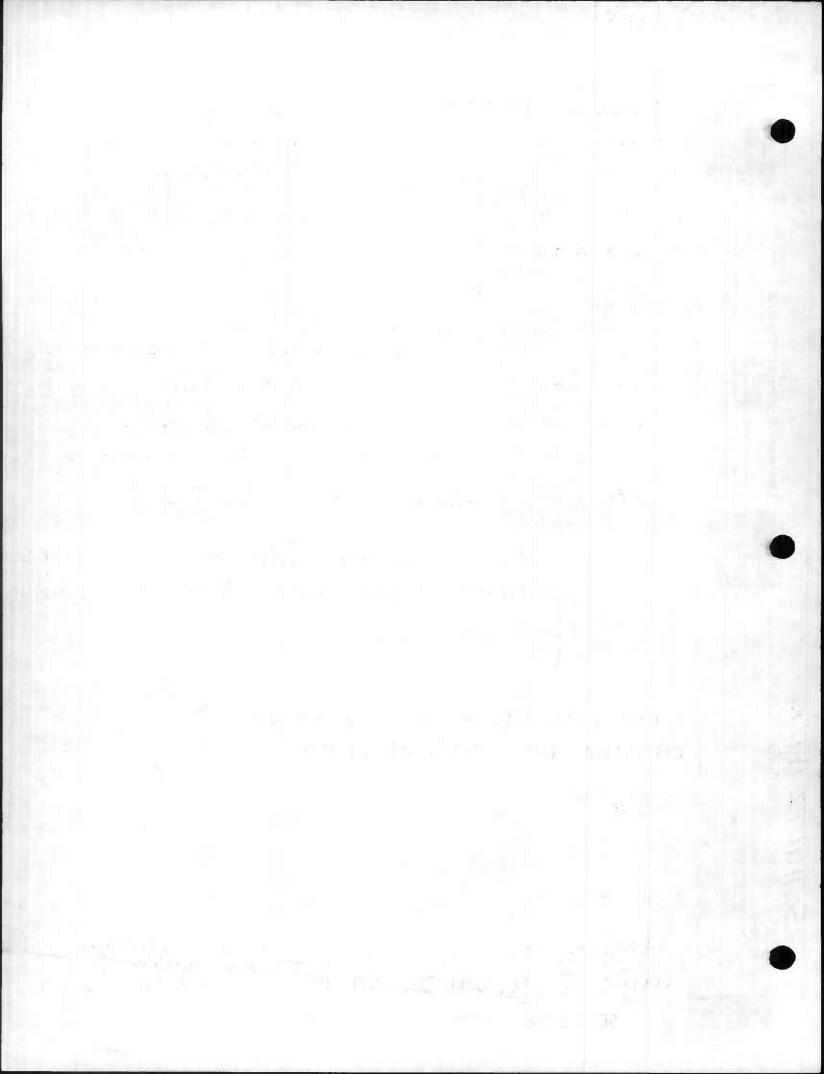


MR#62-41-80

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.
Dhusiaian	Decedent's Name (First, Middle, Last)		2. Data of Death Month Day Year 3. Time of Death
Physician / /Medical	HOLLIS LARUE	SCHULTZ.	Sep 7 98 1230
Examiner	4a Facility Name (If not institution, give straat and number)	4b. City, Town, or Loca	
	CARROLL COUNTY GENERAL HOSPI'		
Funeral Director	215-14-2916 1 ¹ M 25xF 76	rs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Data of Birth (Month, Day, Year) JAN 26,1922 9. Birthplace (State or Foreign Country) MARYLAND
Pu .	Usual Rasidenca of Dacedent 10a. State 10b. County 10c.	City, Town or Location	10d. Inside City Limit
with the Marylar a or 28e-f show be notified at Director	MARYLAND CARROLL	WESTMINST	ER 1 Yes 2 🕅
th with th	10e. Street and Number 52 PENNSYLVANIA AVENUE	10f. Zip Code 21157	10g. Citizen of What Country? USA
aryland 21215-0020 should be filed within 72 hours after death with the Maryland nod Mental bytylene. Insked other than "returel", or items 23e or 28e-f show unstice event, the Medical Examiner must be notified at To Be Completed by Funeral Director.	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. Was Decedant Evar In Armed Forces? 1 Yes, Give Year or Dates:	1 U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Maxican, Puerto Ri 1 □ Yes 2 ☒ No Specify:	ify Yas or No- can, etc.) 14. Race - Amarican Indian, Black, White, etc. Specify: WHITE
15-002 72 hours "natural", edical Exe	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
nd 21215-00 oe filed within 72 has lal hygiena. 2 daher than "netura went, the Medical Be Completed	Elementary/Secondary (0-12) Collega (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired) ASSEMBLY LINE WORKER	TELEMECANIOUE INC
Sor that the Cor	8		~
Maryland 21215-0020 of 2 should be filed within 72 hours aft in and Martal hyghest from "natural", or traumatic event, the Madical Exam. To Be Completed by F	17. Father's Name (First, Middle, Last) WILLIAM H. WISNER		First, Middle, Maiden Sumama) H C. HEDRICK
Aar 2 shc end ls m	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural	
1 and 1 and 2 Health	LINDA BASORE, DAUGHTER		WESTMINSTER, MD 21157
Pagas nent of ant: If it ury or o	20a. Method of Disposition 1 Burial 2 Macremation 3 Removal from State 4 Donation 5 Other (Specify)	p. Place of Disposition (Nama of cametery, crematory or other place) CARROLL CREMATIONS 9	Date 20c. Location - City or Town, State /8 HAMPSTEAD, MD
Baltime permit. Pag Department Important: It any Injury o	21. Signature of Funeral Service Licanses		INE FUNERAL HOME HAMPSTEAD, MD 21074
	23a. Part1. Entar the disaasa, or complications that causad the d shock, or heart failure. List only one cause on each line.		
Physician	SHOCK, OF HEAR FAILURE. LIST OTHY OTHE CAUSE OF EACH TIME.		Onset and Death
/Medical	fmmediate Cause (Final disease or condition	106 ENIC SHO	014 214RG
Examiner		o (or as a consequence of):	
D E	Deute	PILLMONARY	EDEMA 3 HR
68760, ficate be executed physician and is the burial-transit edical Examiner	Sequentially list conditions,	o (or as a consequence of):	
ian a urial.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
68760, ificate be exe g physician s as the burial-ledical Ex		(or as a consequence of):	
C 68 artifica artifica artifica Med			
Box aath ce attandii for use	d	T-FETTE EVENT VILLE	
O. E	Part II. Other significant conditions contributing to death but not	resulting In the undarlying cause given In Part I.	23b. Did tobacco use contributs to the cause of dest
P.O. nat the d by the dateche	ARITIARI GRAT	10 STENDS13	Yes 2 No 3 Probably 4 Unkno
s the se the bed bed bed	CRITICAL FIORI	IC SICINOSIS	
Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed effect death. Director: Attarthis certificate has been signed by the attending physician and binector; page 2 should be deteched for use as the burial-transit ertification: To Be Completed by Physician/Medical Examilential.	CHRONIC OBSTRUC	TIVE LUNG DIS	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Vital Relicion: The law carrificate has rector, page 2 Be Comp			1 Yes 2No 1 Yes 2No
/ita/ita/lian:	25. Was case referred to medical	26. Place of Death	(Check only one)
of V hysica his ca il direc	examiner? 1 Yes 2 No Hospital: Inpatient 2	ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 Residence 8 Other (Specify)
g Ph garth arth	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at 28 Work?	8d. Describe how injury occurred
ndfin ath. r: Aft a fun	Accident investigation	M 1 Yes 2 No	
Vis Atte	3 Suicida 6 Could not be determined 28e. Place of Injury - A building, etc. (Sp.	at home, farm, street, factory, office	St. Location (Street and Number or Rural Route Number, City or Town, State)
Cert Selection	building, etc. (ope	sury)	
Division of Vital Re- To the Hospital or Attending Physician: The law within 24 Hours effected. After this cartificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Comp	29a. Certifier (Check only one) Certifying Physician: To the best of my leading the companient of the	knowledge, death occurred at the time, date and place, ar ination and/or investigation, in my opinion, death occurred	nd due to the cause(s) and manner as stated. d at the time, date and placa, and due to the cause(s)
Withir To the comp	29b. Signature and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
	Haleez A	100 WD 02503	52 914199
	30. Name and address of person who completed cause of death (i	Item 23a) (Type, Print) OLAO I N	83 MILLS MO
	HAFFET A SYL	D 20 Canner R	00 de Dr. 2117
State	31. Date filed (Month, Day, Year) 32. Registrar's Si	gnature	was to
Registrar	SEP 0 8 1998 Sem	B. Spark	



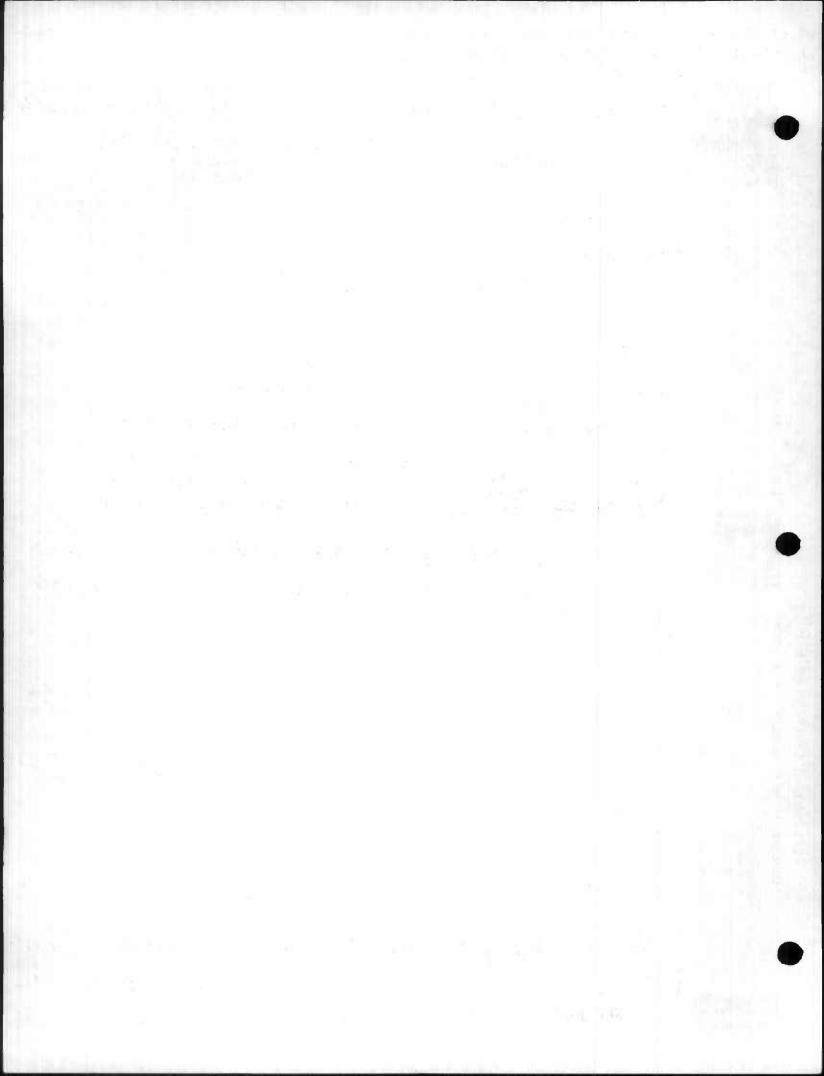
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BIRIR Sepi umpson reorge /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OSDITA! General 6. Sex 1 M 2 □ F If Under 1 Year Months Days 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Birthplace (Stete or Foreign Country) **Funeral** Months Hours 214-10-1336 90 **Director** May Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 No Yes 2 No Director Maryland Carroll Union Bridge 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 238 304 E. Broadway 21791 U.S.A. Hems 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or having yor other traumation. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Fannie Lee Starr George B. Simpson 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 304 E. Broadway Union Bridge, Md. 21791 Patsy Simpson/daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 9/4/98 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State Union Bridge, Md. 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 22. Neme end Address of Facility Hartzler Funeral Home 6 E Broadway Union Bridge, Md. 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** a CONONAY ANTENY

Due to (or as a consequence of): /Medical tmmediate Ceuse (Finel disease or condition resulting In death) Examiner Physician/Medical Examiner that the death certificate be executed physician and sthe bunel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760. Due to (or as e consequence of): 98 Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death?" signed by it 1 Yes 2 No 3 Probably 4 → Onknown Completed by 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Was en eutopsy performed? page 2 certificate 20 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 21 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes Certification: To 1 Inpatient 2 □ ER/Outpetient 3 □ DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural deeth. 1 ☐ Yes 2 ☐ No 2 Accident after deeth Director: 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner as steted. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) end manner stated. 29b. Signature and title of cedific 29c. License number 29d. Date signed (Month, Dey, Year) 221 of deeth (Hem 23e) (Type, Print) 200 Memorial Ave., Westminster, SCHALIBFLAN, M ey, Year) 32. Registrar's Signeture Veneral M MAROLL COUNTY 31 Date filed (Month, Dey, Year) State SEP 0 8 1998 Registrar

SIMPSON

BCAR



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2 Date of Deeth Month 10:50 AM SEP1 4a. Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death WESIMINSTER NURSING-T CONVALESCENTIONES CARROLL 7. Aga (In yrs. last birthday) If Under 1 Yaar Months Deys If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Dey, 6. Sax Birthplece (State or Foreign Country) 10 M 2 XF 213-18-Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits CHEROLL 1 Tas 2 No MACULAND WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21157 STREET APART 30 Locust 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ NO If Yes, Give Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. 11 Marital Status Wes Decedent of Hispenic Ortgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Navar Married 2 Married 1 Yes 2DNo Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) HARRY BARNES HUNTER LENA VIOLA 19a. Informent's Name/Relationship (Type, Print). DALL better 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) PATRICIA 5333 FRITZ Woodville 21771 ANN 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta SEPT 8 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State CARROLL CREMATORY 4 ☐ Donetion 5 ☐ Other (Specify) 1998 21. Signeture of Fur eral Service Licensae 22. Name end Address of Fecility stree! 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errast, shock, or heart feiture. List only one cause on each tine. WESTANSTER, ND. Approximata Intervel Between Onset end Deeth Immediete Cause (Finel diseese or condition resulting in deeth) Due to (or es e consequence of) witne Sequentielly ItsI conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of). Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown NOIL 24b. Were eutopsy findings avellable prior to completion of ceuse of death? 24e. Wes an eutopsy performed? 1 Yes 2 NO 1 ☐ Yes 2 ☐ No 28. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3 No 2 ER/Outpetient 3 DOA

Physician /Medical **Examiner** The law requires that the deeth certificate be executed

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

items ;

natural, or

Hygiene.

is marked other

Important: If Item 27 is any injury or other trai once.

Health end Mental

permit. Pages Depertment of h

Director

Funeral

þ

Completed

Be

2

event, the Medical Examiner must be notified at

with the Maryland

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0020

Box 68760,

P.O. 1

Records,

Division of Vital or Attending Physician:

Physician/Medical Examiner inding physician and use as the burial-tren ettending p signed by the et d be detached for þ page 2 should Completed Deen has certificate director. Be To After this funeral Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Diractor: Afte completely filled in by the fun

25. Wes case referred to medical exeminer? 1∏ Yes 27. Menner of Deeth 5 ☐ Pending investigation

2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

28e. Date of Injury (Month, Dey Year) 28b. Time of Injury

28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 Yes 2 No

258499

28d. Describe how trijury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or Investigetion, In my opinion, death occurred et the time, dete end plece, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and file of certifie

29a. Certifie

29c. License number

29d. Data signed (Month, Dey, Year) 1998

30. Name and address of person npleted cause of death (Item 23e) (Type, Print) 4900

31. Dete filed (Month, Day, Year) State Registrar

Medical

SEP 0 8 1998

32. Registrer's Signature

· noientre

WRC 98-5205-041 JOHN SEAT

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

vsician				Certifica		lealth a			Reg. No.	3 20	102	
Medical	Decedent's Neme (First, Middle, JOHN GRANT	SEATON						2. Dete of De Month SEPT.	oth 04 1998	Yeer	3. Time of Deeth 3:30 PM.	
kaminer	4e Facility Neme (If not institution, EASTON MEMORIA						wn, or Lo	cation of Deeth	4c. County			
neral ector	5. Sociel Security Number 220–32–8990	177M OFF	Age (In yrs. last b	Yrs. If Unde Months	Deys	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da MAR • 23	th y, Year) , 1923	9. Birthplec Country, ENGL.	e (Stete or Foreigr AND	
led at	Usuel Residence of Decedent 10a. Stete 10b. County MD TALBC)T		wn or Location	H					10d.	Inside City Limits 1 X Yes 2 □ No	
at be notified	10e. Street and Number 211 BROOKLETTS	AVENUE			Coda	1			10g. Citizen of V		?	
Examples rount be notified at by Funeral Director	11. Merital Status 1 Never Married 200 Merries 3 Widowed 4 Divorced	12. Was Deceder Armed Force	s? () No	13. Was Dece	dent of H		gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 14. Rec	e - American ck, White, etc		
any injury or other traumatic event, the Madical Exponent. To Be Completed by	15. Decedent's (Specify only highest Elemantary/Secondery (0-12) 12			a. Decedant's Usu (Give kind of we life. DO NOT u	ork done ise retire	du <i>ri</i> n <i>g m</i> os d)	t of worki	ing	16b. Kind of B			
To Be	17. Father's Name (First, Middle, La THOMAS HARDMAN								Meiden Suman MARY G			
or trauma	19a. Informant's Nama/Raletionship MARGARET MARIE			b. Mailing Addras							oda)	
ry or other	20e. Method of Disposition 1 Buriel 2XICremetion 3 Removel from State 4 Donetlon 5 Other (Specify) 20b. Plece of Disposition (Neme of cametery, crematory or other pleca) CHESAPEAKE CREMATION CTR 20c. Location - City or Town, Security of State CREMATION CTR 9-10-98 CHESTER, MD											
any inju	21. Signature of Funeral Septice Li		g/		S, H	ELFEN	BEIN		IAM FUNE		ME, P.A.	
cian dical liner	23e. Pert1. Enter the diseese, or or shock, or heert feilure. List or Immediete Ceuse (Final diseese or condition resulting in death)	omelicetions thet caus nly one ceuse on each e.	Mul		de of dyli					A	pproximate tervel Between nset end Deeth	
s the burial-transit edical Examiner	Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Causa (Disaasa or Injury that initieted events resulting in death) Last	b		consequence of)								
for use es		d						ook bla	A-1			
ese L	Pert II. Other significant condition	ds contributing to death	but not resulting	in the underlying	cause gi	van in Pert I	l.		tobacco use co	entribute to the	ne cause of death	
be detached by Phys	Pert II. Other significant condition	ds contributing to death	but not resulting	in the underlying	cause gi	wan in Pert I	l.	1 D	4.	3 Probet	eutopsy findings bble prior to letion of cause	
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rector, page 2 should be detached by Be Completed by Phys	25. Wes case referred to medical exeminer?	Hospital:			Ott	28. Plece	e of Deetl	24a. Wes perfit INSPI	en eutopsy med? ECTION Yes 2 No	24b. Ware eveile comp of der	eutopsy findings ble prior to letion of cause ath?	
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29c. License number O.C.M.E. 29d. Dete signed (Month, Dey, Year) SEPT. 05, 1998

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

J. Laron Locke M.D. 31. Dete filed (Month, Dey, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

SEP 1 0 1998

32. Registrer's Signeture

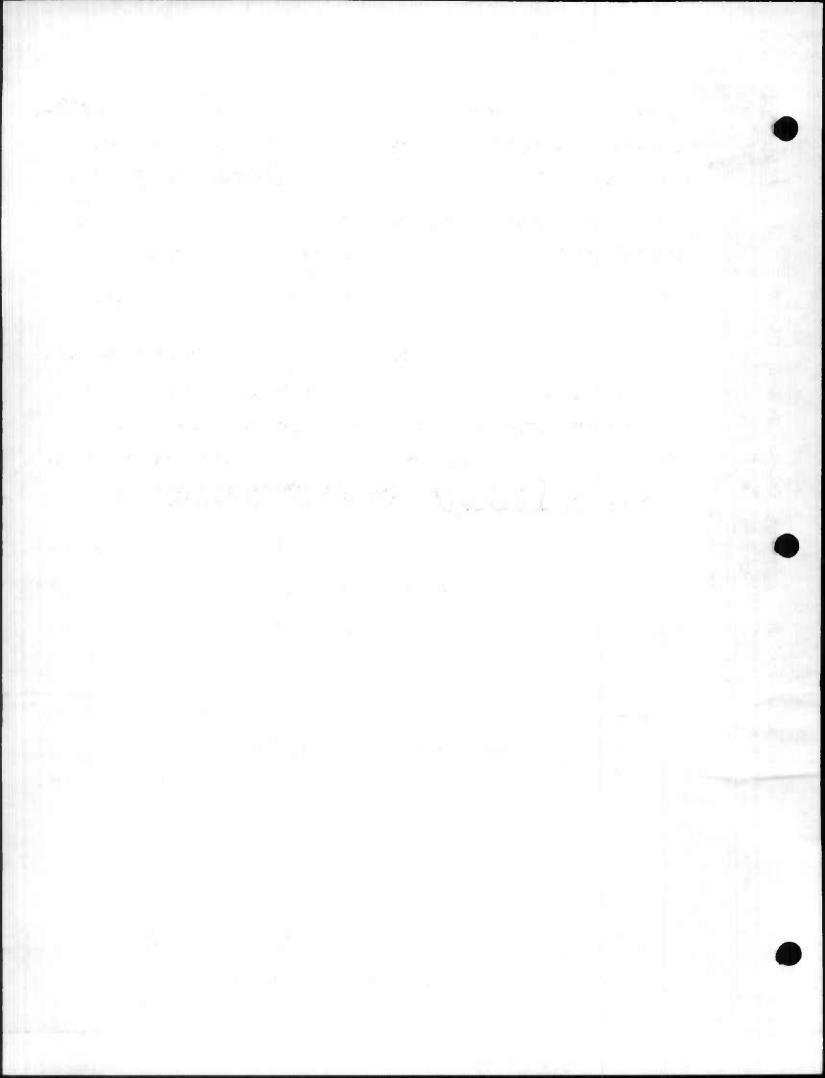
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** SEPTEMBER 8,1998 DONALD LEE SMITH /Medical 4e. Fecility Neme (If not institution, give street end number) 4b City Town or Location of Deeth 4c. County of Death Examiner CENTREVILLE Q
If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) CORSICA HILLS NURSING FACILITY OUEEN ANNE Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Months 15 M 2□ F 75 Vrs Director APRIL 30,1923 VA. 230-14-9615 Usual Residence of Decedent the Maryland r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director MD QUEEN ANNE CENTREVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Hastlin and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any fulury or other traumatte event, its Med. 200 RHYANES LANE 21617 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify:BLACK à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) LABORER MACHINE OPERATOR 08 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 20 MATHEW WALKER ELIZABETH COBBS 19e. Informent'e Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSE GREENE/ DAUGHTER 517 MAIN ST. CHURCH HILL, MD. 21623 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State Donation 5 Other (Specify) BENEFICIAL ASSC. 9/12/98 CENTREVILLE, MD. 21. Signeture of Funerel Service License 22. Neme end Address of Fecility DASHIELL FUNERAL SERVICES AVE. EASTON, MD. 21601 322 EAST 23e. Pert1. Enter the disease, or complications that coused the deeth. Do not enter the mode of dylng, such as cardlac or respiretory errest, shock, or heart feilure. List only one cause on each line. Interval Between Onset end Death **Physician** Evorcho preunoma /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner ician and burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Last physician s the buria Box 68760. Physician/Medical signed by the a Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? Records, P.O. 1 □ Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown À Left upper lobe neoplasm - Lung Zyn 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? should I Completed 24e. Wes en eutopsy performed? After this certificata has 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was cese referred to medical Be 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? To the Hospital or Attanding F within 24 hours after death.

To the Funeral Director: After 1 Naturel 5 Pending investigation 2 Accident 1 Yes 2 No Director: in by tha 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and menner stated. Medical 29a. Certifier complataly 29b. Signeture end title of partition 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 2540 CENTREVILLE, MD. 21617 RUSSELL SHILLING, D.O. 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State SEP - 9 1998 Janen Registrar



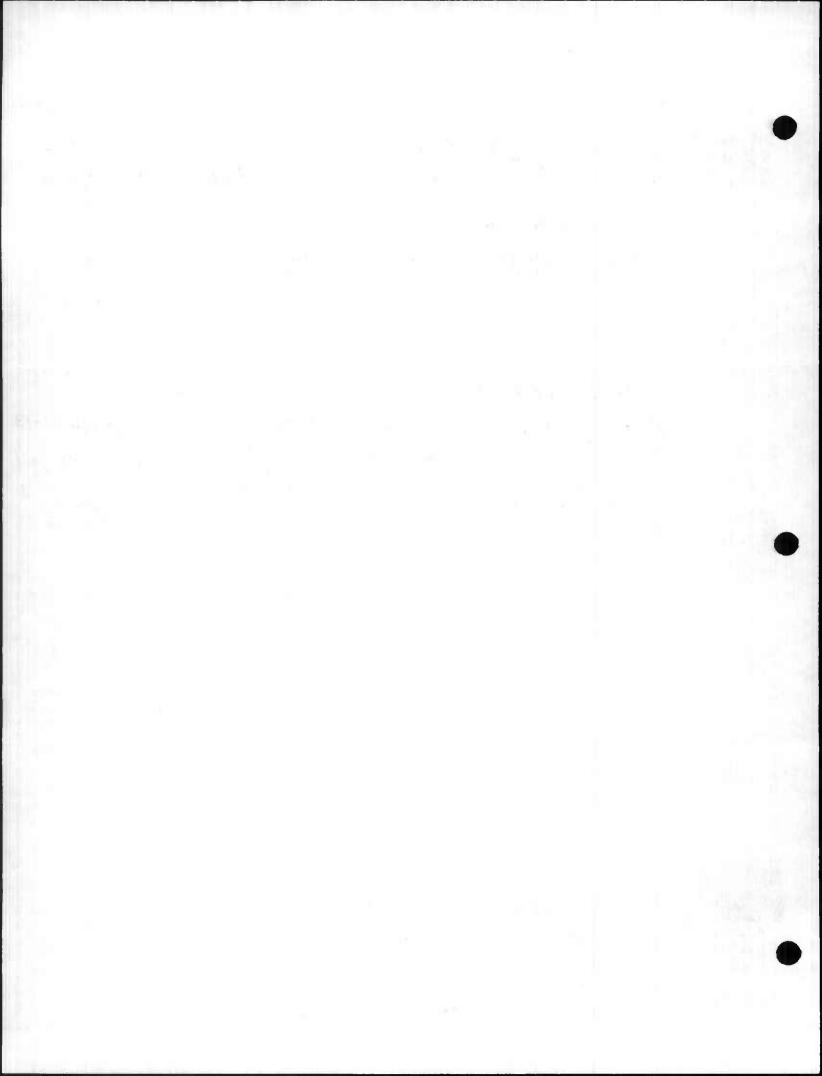
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Physicla		Decedent's Name (First, Middle, La	st)		orumouto or	Death	2. Dete of Dee	leg. No. 🤰 🤇 th	3 64	3. Time of Deeth		
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/Medic	_	4e. Fecility Neme (If not institution, giv	e street and numbe	r)		4b. City, Town, or		4c. County		3.35p.m.		
	_	Chestertown Nursi	ng & Reha	bilitatio	n	Chester	town	Ker	nt			
Funerai		5. Social Security Number 6. S		Age (In yrs. lest birtho	day) If Under 1 Yeer	If Under 24 Hrs		Year	9. Birthp	lece (Stete or Foreign try)		
Director		212-40-9193 Usuel Residence of Decedent		J/ 11	5.		August 21	, I941		tertown, M		
how		10a. Stete 10b. County		10c. City, Town o	or Location				1	Od. Inside City Limits		
28a-f show	ctor	Maryland Kent		Cheste	rtown					1X Yes 2 No		
or 2	Dire	10e. Street end Number			10f. Zip Code			Og. Citizen of \	Whet Coun	try?		
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o',	by Funeral Director	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Deceder Armed Forces 1 Yes 24 If Yes, Give Year or Detes	No	13. Wes Decedent of If Yes, specify Cub 1 ☐ Yes 2 No		pecify Yes or No- o Rican, etc.)	Bled	e - Americ ck, White, o : Whi	etc.		
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merk	2	Milburn Jackson S ¹ 19a. fnforment's Neme/Reletionship (10h A	Neiling Address (Stree		Louise St		Chara Tin	0-4-1		
27 is me		Douglas L. Smith/			Farwell R				1620	Code)		
item 27 other tr	-	20e. Method of Disposition	· · · · · · · · · · · · · · · · · · ·		isposition (Name of cremetory or other pie		Dete	20c. Location -		wn, Stete		
Important: If it any injury or o		1 XBuriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specific		0			r 6 190	8/Ches	terto	wn MD		
Important: If Item 27 is any injury or other trait		4 Donetton 5 Other (Specify) Chester Cemetery/September 6, 1998/Chestertown, 21. Signeture of Funeral Service Liberage 22. Name and Address of Facility										
any ir		Fellows, Helfenbein & Newnam Funeral Home, F 130 Speer Road, Chestertown, Maryland 21620 Approximate shock, or hear fellure. List only one ceuse on each line.										
g physicia es the bur	8	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest	b. Castle	Due to (or es e con	Sp/a d	6 coll	cn.).			3/4		
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State of Maryland / Department of Health and Mental Hygiene 9 8 29 105

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Essent.	-	5. Social Security Number 6. Se	Reys Ro		ndar 1 Year If Under 24 Hr	bRidge s. 8. Date of Birth		RChes	
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0 1	by Funeral Director	1) Never Married 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 Yas 2 No If Yes, Giva Yaar or Dates:		ecedent of Hispanic Origin? (specify Cuban, Mexican, Puess 2) No Specify:	rto Rican, atc.)		ck, White, atc.	CK
"neturel"		15. Decedent's Edu	cation	16a. Decedent's L	Isual Occupation	16	6b. Kind of Bu	usiness/Industry	
	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of life. DO NO	work done during most of w Tuse retired)	orking	, ,	1.4	
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int:		1 Burial 2 □ Cremation 3 □ 8 4 □ Donation 5 □ Other (Specify,		cometery, crematory	1001 CAMETERY	01		1	Wary low
Department Important: I any injury once.		21. Signature of Funeral Servica Licens 23a Paul Enter the disaase, or component or heart failure. List only o	0.76.	1 Hen	and Address of Facility RY FUNERAL	Home P.A	1.	1.04.	21613
		23a Part Effer the disease, or comp	ications that caused the de	atty Do not enter tha r	node of dying, such as cardle	Tr CUMBI ac or raspiratory arres	ridge,	Marey/a	oximata
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unera unera	Certification:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe how	injury occurr	red	
Director: A d in by the fi	cat	2 Accident Investigation 3 Suicide 6 Could not be	and Discontinuous	M	1 Yes 2 No	DOL Leasting (Con-		D = 10-1	About
Director: After		4 Homicide determined	28e. Placa of Injury - At building, etc. (Spec		tory, office	28f. Location (Stre City or Town,		er or Hural Rout	e Number,
		29a. Certifler (Check only one) 2 Medical Examination	ner: On the basis of examir	nowledge, deeth occurr nation and/or investigat	ed at the time, date and plection, in my opinion, death occ	e, end due to the cau curred at the time, date	se(s) and ma and pleca, o	nner as stated. and due to the ca	ause(a)
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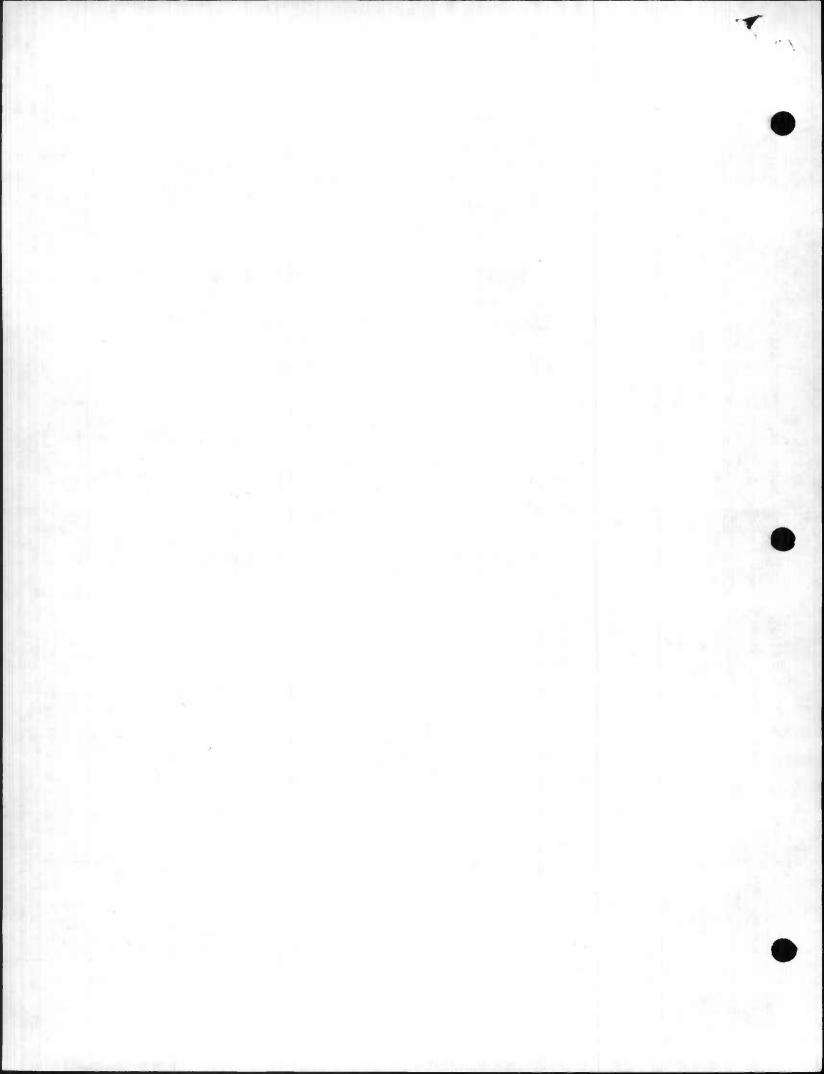
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		e of Death	Reg	50	29106
nysician Medical	Decedent's Nama (First, Middle, Last) ELSIE MABEL TIMMERMAN		2. Data of Death Month SEPTEMBE	R 6, 1998	3. Tima of Deeth 5:40 P.M.
xaminer neral	4e. Fecility Nama (If not institution, give street and number) DENNETT ROAD MANOR NURSING HOME 5. Sociel Security Number 218-10-0130 6. Sex 7. Aga (In yrs. last birthday) Months Months	4b. City, Town, or Loc OAKLAND 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yo	GARRETT 9. Birt 1902 MAR	
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	17. Fether's Nema (First, Middle, Last) AMOS BITTINGER	18. Mother's Neme ELIZAE			ENNEMAN
other traumatic	19e. Informent's Ne <i>me</i> /Reletionship (<i>Type, Print</i>) HELEN CLARY - DAUGHTER 19b. Mailing Address 99 HOLLY 20e. Method of Disposition 20b. Plece of Disposition (Nem		LAKE P	City or Town, Steta, 2 ARK, MD 2 c. Location - City or	1550
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any	W/2 X 111/1 L	ST FUNERAL HO	ME - OAK		21550 Approximate tritervel Between
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ed in by the funeral ond	2 Accident Invastigation M 3 Suicide 6 Could not be	3c. Injury at Work? 1 Yes 2 No	28d. Describe how	ce 6 Other (Special Injury occurred et end Number or Ru	
completely filled in by Medical Certif	4 Homicide determined 29e. Certifier (Check only) Medical Examinar: On the basis of examination and/or invastigation,	at the time, dete end piece, e	City or Town, S	Stete) se(s) end menner es	steted.
completely filled in by Medical Certifi	29b. Signature end tillest certifier 29c.	License number	29d.	Dete signed (Mont	h, Day, Year)
2	30. Nerpe end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) ROGER A. LEWIS, M.D. 510 W. STATE AVE.	TERRA AI	LTA, WV	26764	
State egistrar	31. Dete filed (Month, Dey, Year) SEP = 9 1998 32. Registrer's Signetura	abs			

The state of the s Message 178, 178-1 FROM 1 1932

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		C						
_	I. Decedent's Nama (First, Middla, Last)			100	2. Date of I	Death Day	Year	3. Time of Death
cian lical	Yeung Tam						1998	10:00
	a Facility Nama (If not Institution, give street and number)		170	4b. City, Town,	or Location of De	ath 4c. County	of Death	
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	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs.					of Birth of, Day, Year) 9. Birthplace (Stata or Forei Country)		
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	10a. Stete 10b. County 10c. City, Town or Location						10	0d. Inside City Lim 1 ☐ Yes 2 ☑
cto	MD Montgomery Silver Spring							
Director	10e. Street and Number 10f. Zip Code					10g. Citizen of What Country?		
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by F	H Vac Gara					Specify: Asian		
						ASIan		
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2						eung Wong		
						ral Routa Number, City or Town, State, Zip Code)		
	Po-King Tam (wife)			Court, Si	lver Spr		20904	
	cometany cramatony or other place)						- City or To	wn, Stata
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Sept. 6, 1998 1:03AM Margaret Mary Tappan

4b. City, Town, or Location of Death

4c. County of Death

Physician /Medical Examiner

4a Facility Nama (If not institution, give street and number)

Funeral Director

ahova 28a-f "naturel", or hems 23s or 72 hours after Hygiene. partnit. Pages 1 and 2 should be file Oppartment of Health and Mental Hy Important: if Item 27 is marked othy any Injury or other traumatic event DOSS.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and the burial-transit that the death certificate be executed Box 68760 attending p Records, P.O. signed by t peeu 785 Division of Vitai or Attending Physicien: this

Examiner Physician/Medical by Completed Be P Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun. edical 35

Montogmery General Hospital Olney Montgomery M Under 24 Hrs Birthplaca (Stata or Foraign Country) # Under 1 Year 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days Hours 1□ M 2⊠ F Months Yrs. 94 28, 1903 Oct. Washington, 579-60-3858 Usual Rasidence of Deceden 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Vas 2 X No Director MD Montgomery Bethesda 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9809 Brixton Lane 20817 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Statue 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ⊠ Nevar Married 2 ☐ Married 1 Yes 2 No Specify: Specify: À White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Library of Congress/ College (1-4or 5+) Elementary/Secondary (0-12) Librarian Federal Government 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) 86 William F. Tappan Nora McKnight 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Thomas W. Tappan 9809 Brixton Lane, Bethesda, MD (Nephew) 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 9/10/98 Washington, DC 22. Nama and Address of Facility Francis J. Collins Funeral 21. Signature of Funeral Service Licenses 500 University BLvd. West Home, Inc. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Immediata Causa (Final diseasa or condition resulting in death) UROSEPSIS 5 DAYS. Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ATRIAL FIBRILLATION 1 Yas 2 No 1 ☐ Yas 2K No CORUNARY ARTERY DISEASE 25. Was casa rafarred to medicat axaminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yas 20 No Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to the causa(s) and manner stated. 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number W.D SEPTEMBER 7 1990 235941

State

Registrar

PURAN P.

31. Data filed (Month, Day, Year)

SEP

50 W.

EDMONSTON

DR.

ROCKVILLE MD 20852.

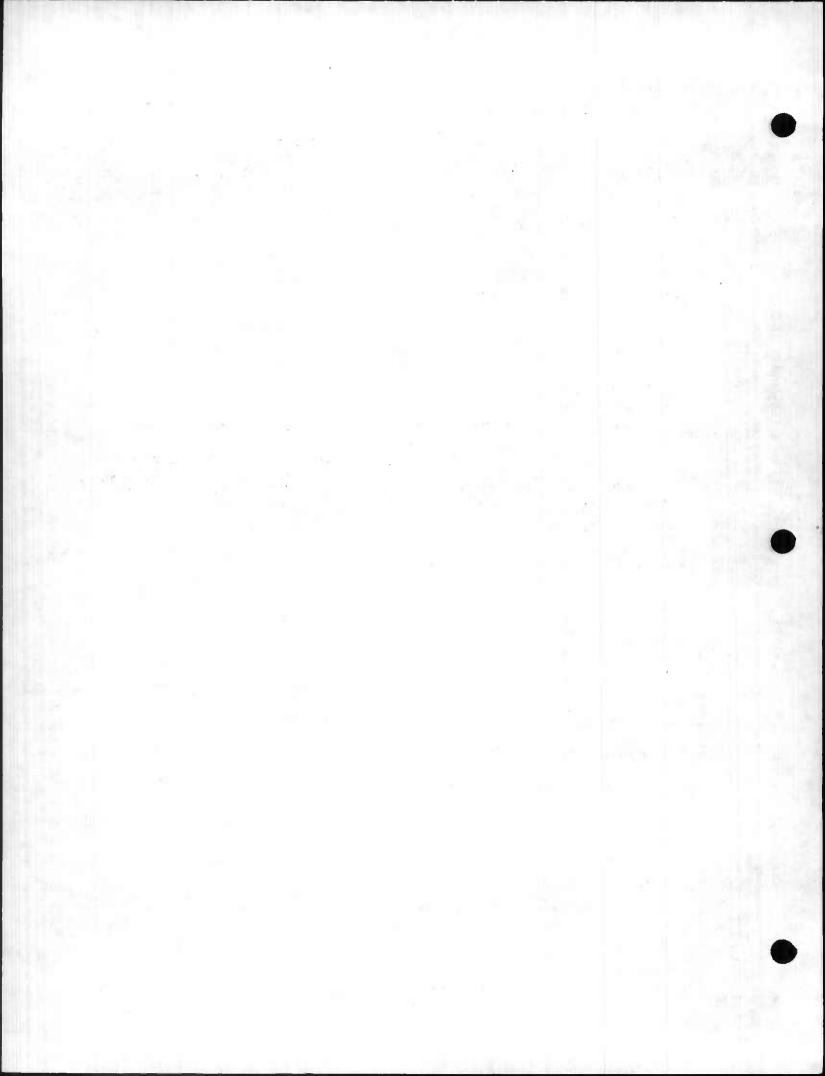
30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

401

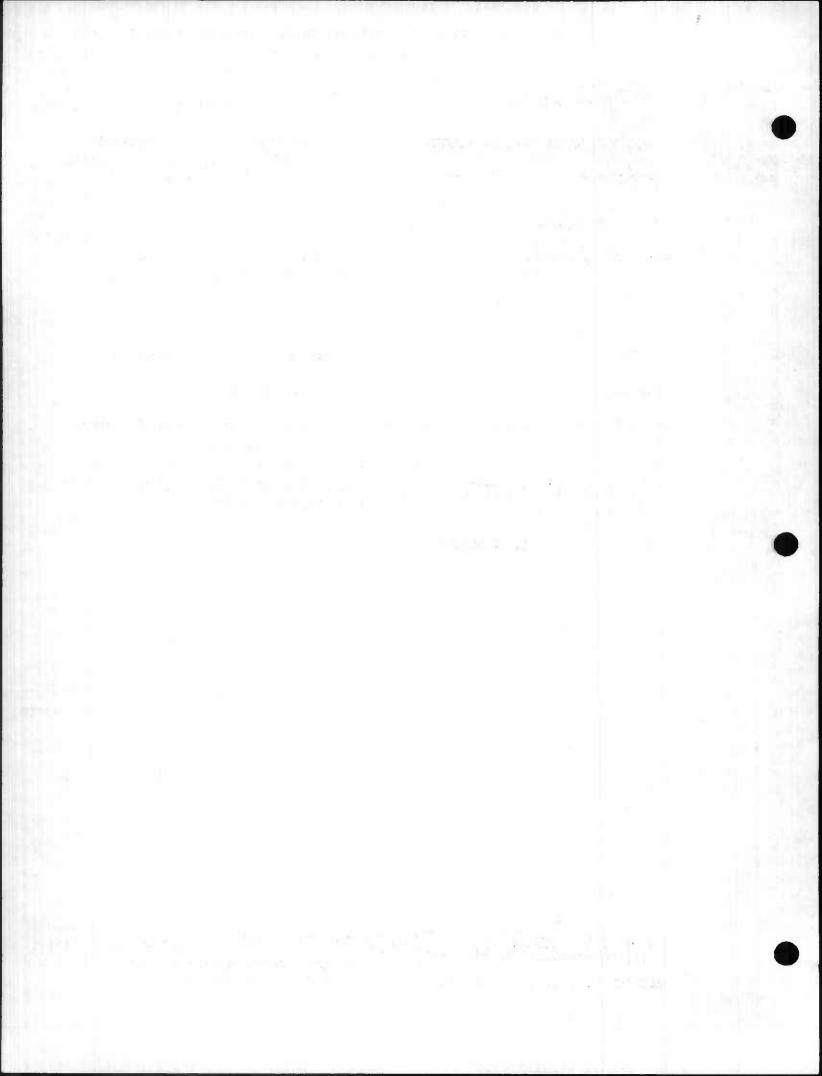
32 Registrar's Signature

MATHUR

0 8 1998



		1. Decedent's Neme	e (First, Middle, L	ast)		BIL	Certificate	OI I	Deam	2. Dete of De	Reg. No.		3. Time	e of Death
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Funeral Director		5. Sociel Security N 216-50-	8405	L MEDIC Sex 1□M 2☑F	7. Age (I	SNTER n yrs. lest b 50	Yrs. If Under 1 Months I		BETHESDA If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di Nov. 1	rth ev. Year)			ite or Foreigi
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or he	by Funeral	11. Marital Stetus 1 ☐ Never Marri 3 ☐ Widowad	ed 225 Married	12. Wes Dad Armed For 1 Tyes If Yes, Gi Yeer or D	orces? 2⊠No ive	r in U,S.	13. Was Deceder If Yes, specify		ispenic Origin? (Sp in, Mexicen, Puerto Specify:	ecify Yes or No Ricen, etc.)	Speci	ice - Americ eck, White, ify: Wh		ų
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af or Attend s aftar deeth il Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l detarmined	Zoe. Place	e of injury ling, etc. (S	At homa, f	arm, street, factory, o	office		28f. Location City or To	(Street and Num wn, Stata)	ber or Rura	/ Route N	lumber,
To the Hospital or Atter within 24 hours after de To the Funeral Directo completaly filled in by the	edicai (29a. Certifier (Check only one)	Certifying P	miner: On tha b	a best of m pasis of axe	aminetion el	a, death occurred et ad/or invastigation, in	the tim	na, deta and place, pinion, deeth occur	and due to the red et tha time,	ceuse(s) end n data and place	nenner es st , and dua to	eted. tha ceus	se(s)
To the within 2	Me	≥ M L	ohow	PK	ue.		m) 01	010	58187 (V		29d. Date sign	05	Dey, Yea	1998
		30. Name end aldra MICHAE	L P. KEI	TH, LT,					NAL NAVAI			EK	ď	
Sta Registr		31. Dete filed (Mont	h, Day, Yeer) SEP 0 8 1		Registrer's	-	B. So	4	1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Monti 1:25P EBEAU 1998 WILLIAM City, Town, or Location of Death 6. 4c. County of Death Name (If not institution, give street end number) Montgomery Valley Nursing Kockville Home if Under 24 Hrs. 8. Date of Birth Month Day, 1915 9 Firthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number XX M 2 F 83 Yrs. Montha Days Hours Min. NewYork 096-12-4286 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 X es 2 □ No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 United States 3304 Pennsylvania Street 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 1 No If Yes, Give Year or Datas: Race - American Indian Black, White, etc. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Nevar Married 2 Married specify: White 1 Yes 2 XXio Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Harry Diamond Elementary/Secondary (0-12) College (1-4or 5+) Laboratory Shop Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrews Thiebeau Mary Jerry 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) same as #10 Ruth H. Thiebeau (wife) 20b. Placa of Disposition (Nama of cematery, crematory or other place) Date 20c. Location - City or Town, Stata 4 Donetion 5 ☐ Other (Specify) Metropolitan Crematory 9/8/1998 Alexandria, Virginia Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Daath 23a. Part1. Entar the diseese, or shock, or heart failure. List Immediate Cause (Final disaase or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of): that initiated events rasulting in daath) Last Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evallable prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 ENO 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Be

Funeral

Director

7 is marked other than "natural", or itams 23a or traumatic event, tre Modical Examinar must be a

permit. Peges 1 and 2 should be filed within 72 hours efter deeth 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a and Injury or other traumatic event, tra Medical Examinatornals.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records,

with the Meryland r 28a-f show

ettending physician end for use as the buriel-transit that the deeth certificate be executed signed by the e lew requires been sig page 2 s has certificate or Attending Physician: director,

After this funeral deeth. efter

Physician/Medical by Completed Be To 27. Manner of Death Certification:

1 ☐ Yes

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

SEP

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5 Pending

invastigation

6 Could not ba determined

Examiner

ector: 2 24 hours efter Funeral Dire letely filled in b

To the Hospital o within 24 hours of To the Funeral D completely filled i 3

edicai

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifian

28a. Date of Injury (Month, Dey Year)

1 Inpatiant 2 ER/Outpatient 3 DOA

28a. Place of injury - At homa, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

28c. injury at Work?

1 Yes

2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

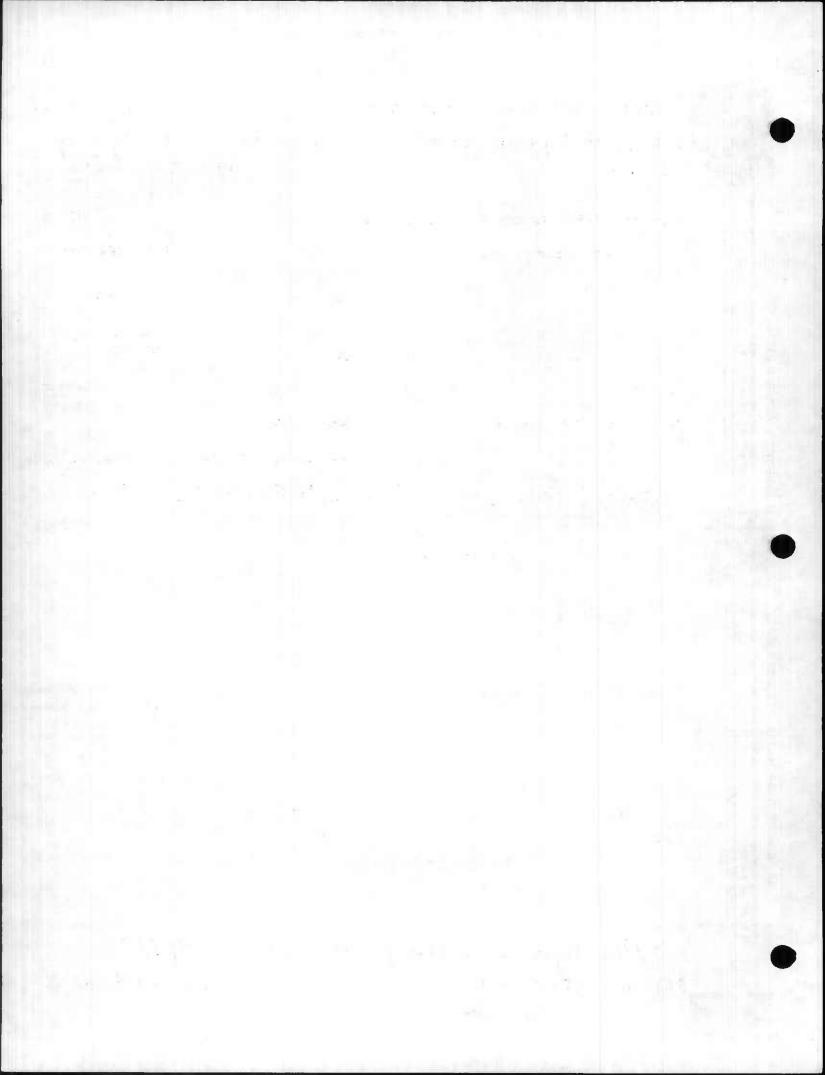
28d. Describe how injury occurred

no completed cause of death (Item 23a) (Type, Print) Name and eddress of person Georgia

1998

Registrer's Signature

201 Silver Spring, Md. 20902



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nema (First, Middle, Last) 2. Data of Death 3. Time of Death September Day, 1998 **Physician** 7:30AM Dao T. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Gaithersburg Montgomery 517 Mandolin Court H Under 1 Year H Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

Dec ember 31, 1918 9. Birthplace (State or Foreign Country) 8 Vietnam 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2QF Yrs 79 227-41-8521 Director **Usual Residence of Decedent** the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits se filed within 72 hours after death with the Manylan of Hyglene.

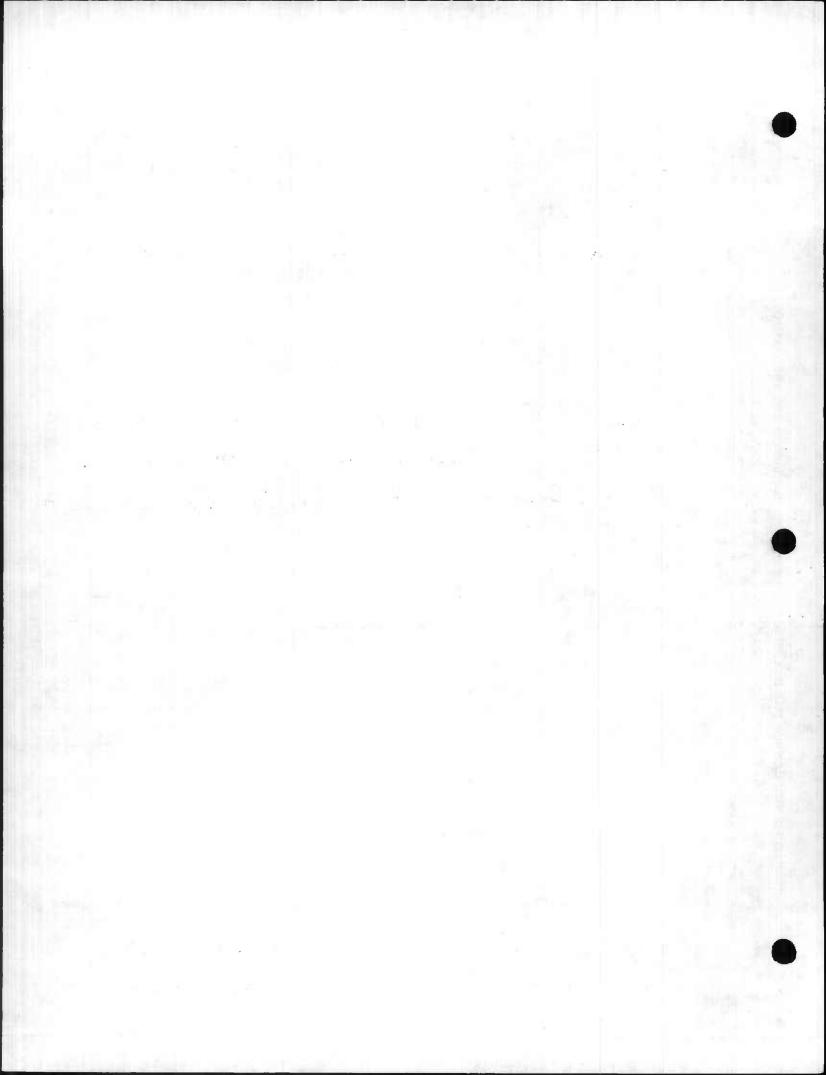
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In Hyglene and the service of the Annandale 1 Yes 2 No Fairfax Virginia Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 22003 Vietnam. 4106 Mangalore Drive #203 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Asian 21215-0020 1 Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) "Own Home" permit. Pages 1 and 2 should be illed a Department of Health and Mental Hygie Important: If Nem 27 Is marked other to pay Injury or other traumatic avent, the pinca. Home Maker 17. Father's Neme (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be To Thi Ty Tran Ly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 517 Mandolin Court, Gaithersburg, Maryland 20877 Boi Vuong Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 9-8-98 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park Fairfax, Virginia 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Robert J. Murphy Funeral Home, Inc. Busch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

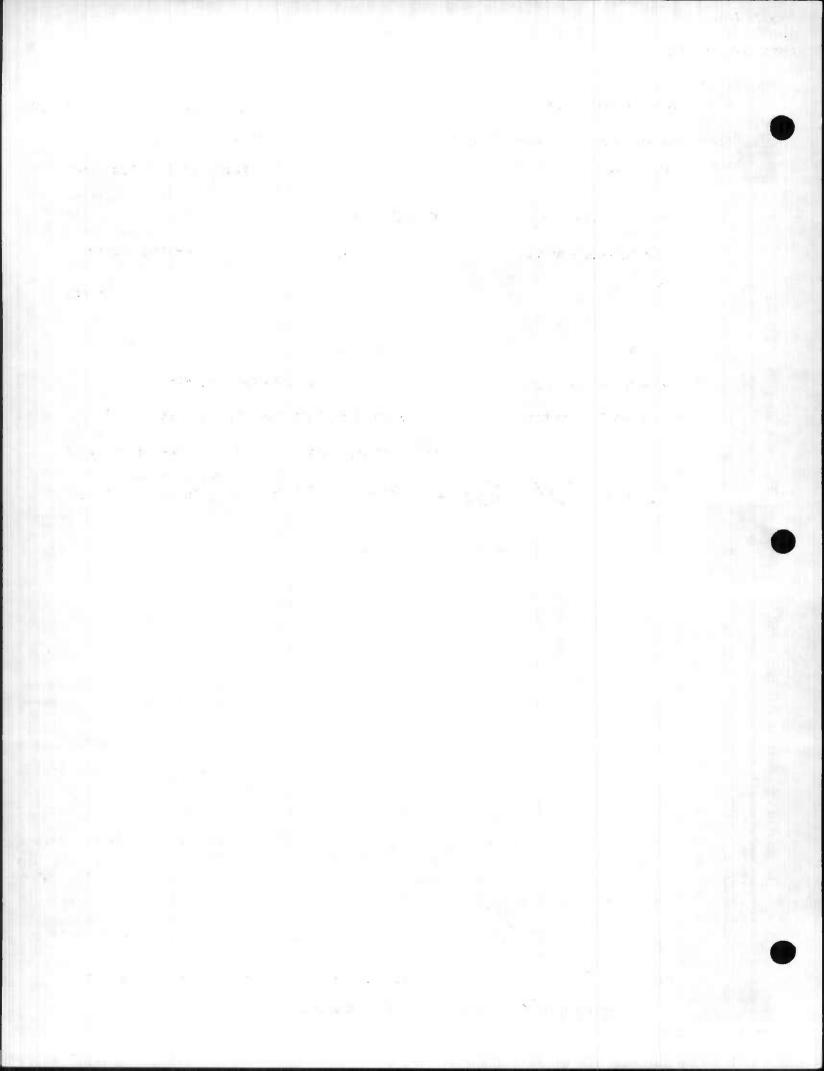
Approximate

Approximate mana Interval Between Onset and Deeth **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Emphysema Due to (or as a consequence of): Physician/Medical Examiner Cardiac Failure physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Box 68760. Cardiac Arrhythmia that initiated events resulting in death) Last Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy lindings available prior to completion of cause ol deeth? Be Completed 24a. Was an autopsy performed? page 2 s has director, page 1 Yas 20 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Wother (Specify) Son's home 1 Yes 2 No edical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending After Division 5 Pending investigation 1. Netural death. 1 Yes 2 No 2 Accident Director: 281. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) after 4 | Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 010131757 Virginia Sept. 1.1998 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Harold T. Facen, MD 611 South Carlin Springs Road, Arlington, Va 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State **SEP 1 0 1998** Registrar



State of Maryland / Department of Health and Mental Hygiene

		s Name (First, Mic								2. Date of De	eath Day	Year	3. Time of De
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ner	4a Facility	ama (If not institu	tion, give s	treet and number	er)				4b. City, Town, or			unty of Dea	th
		ll County			_		III I to ele		Westmins			rroll	
r	215-4	curity Number 9-7812 ence of Decedent	6. Sex	M 2□F 7.	Age (In yrs.	last birthday) 1 Yrs.	Months	Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, De March	th ly, Year) 15,199	7 Mar	thplace (State or Fountry) yland
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to	MD	Car	roll		1	Westmin	nstei						1 ∑ Yes 2
rec	10e. Street	nd Number				100	10f. Zi	p Coda			10g. Citizen	of What Co	ountry?
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by Funeral Director		tatus or Married 2 M owed 4 Divord	larried	2. Was Decede Armed Force 1 Tyes 2 f If Yas, Give Year or Data	s? XNo		Vas Dece i Yes, spe		dispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		Black, Whit	erican Indian, te, etc. White
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	The second	nt's Name/Relation							and Number or Re Avenue,				
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	1	allet	H	11/10	ers	- MY	vers	rune	eral Home	Westm:	inster	, MD	21157
Medical Examiner	Sequentially if any, leading cause. Entre Cause (Dise that initiated resulting in	list conditions, og to immediate ir Underlying ase or injury evants death) Last	{ °			r as a conseq							
Physician	Part II. Othe	aignificant cond	itiona con		but not res	ulting in the u	nderlying	cause gi	ven in Part I.	23b. Dld	tobacco ue	e contribut	e to the cause of
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Completed by										24a. Was perf	s an autopsy ormed?	24b.	Were autopsy fine available prior to completion of cau of death?
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Be (25. Was cas examine	a rafarred to mad								ath (Check only	one)		
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0		ral 5 Pan	stigation	9-6.	Day Year) - 98 Injury - At he etc. (Specif	Injury (5 30 ome, farm, str y)		1 🗆	Yes 27 No	City or To	(Street and Nown, State)	, we	My COLLA Rural Route Number Stminsky
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Certification: To	1 Natt 2 Acc 3 Sui 4 Hor	r 1 Certif	ying Phye	Iclan: To the be	coude st of my kno of examina	wiedge daath	occurred restigatio	at the ti	me, date and place	e, and dua to the	cause(s) an	d manner a	is stated.
10	1 □Natt 2 ☑ Acc 3 □ Suit 4 □ Hor 29a. Cartifie (Check one)	r 1 Certif	ying Physical Examin	Iclan: To the be	Coud (wiedge daath	estigatio	n, in my o	me, date and place opinion, daath occurse number O.C.M.E.	e, and dua to the	cause(s) and, date and place	d manner a ace, and du	is stated.

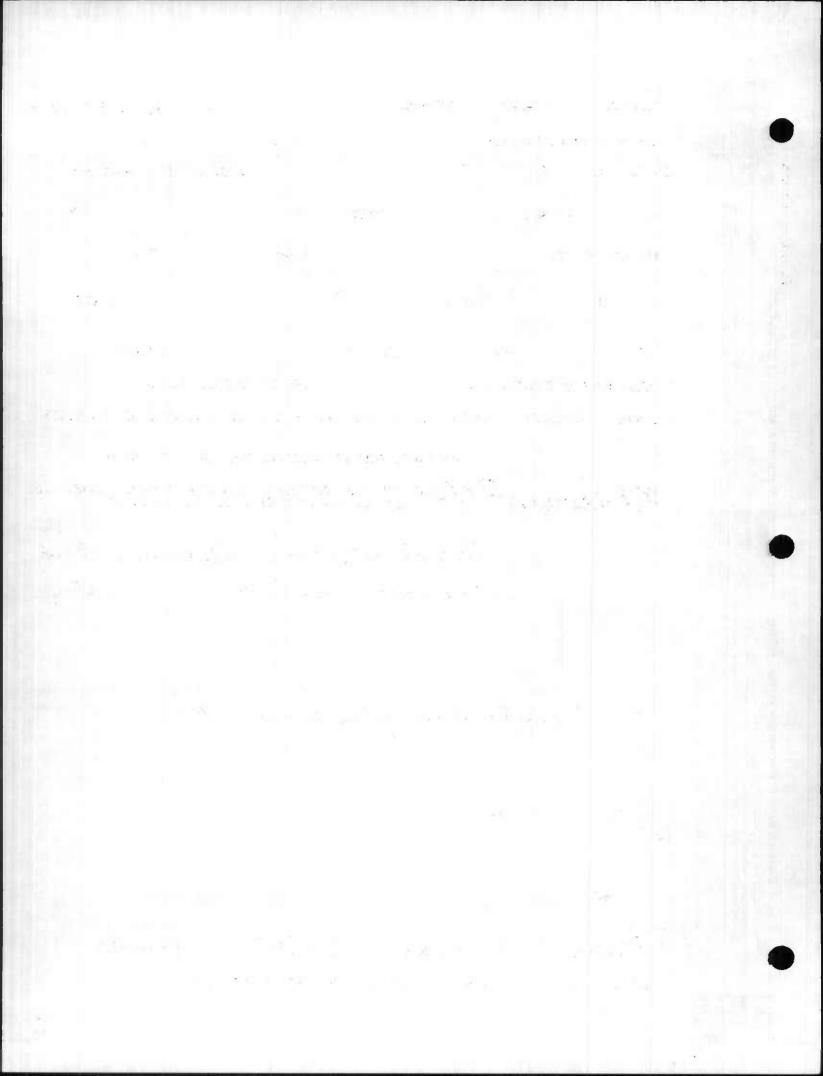


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** WILLIAM **EDWARD** THOMAS. JR. 10, 1998 2:08PM Sept. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner The Memorial Hospital Talbot Easton If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) AUG. 24, 19 William Thomas 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** X□M 2□F 72 MARYLAND 215-20-2647 1926 Director Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-1 show any highry or other traumatic avent, the Mooircal Examiner must be notified at once. EASTON XXYes 2 No MD TALBOT Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 313 CHERRY ST. 21601 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 △Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Biack, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2XXNo Specify: Baltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 🖾 Divorced WHITE Year or DatesWW II Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRIVER TAXICAB 10 18. Mothar's Name (First, Middle, Meiden Sumeme) 17 Father's Name (First Middle Last) Be WILLIAM EDWARD THOMAS, SR. MARY ELIZABETH DARRELL 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Raiationship (Type, Print) MELINDA L. SCHULTZ/ DAUGHTER 21182 MARSH CREEK RD., LOT 50, PRESTON, MD 21655 20b. Piace of Disposition (Neme of cematary, crametory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2 Cramation 3 Removat from State MARYLAND VETERAN CEMETERY 9-14-98 BEULAH, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST., EASTON, MD 21601 HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each lina. Approximete interval Between Onset and Deeth **Physician** /Medical immediata Causa (Final disease or condition rasulting in death) Millervaller Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execu-Due to (or as a consequence of) and physician Division of Vital Records, P.O. Box 68760 Physician/Medical 96 Due to (or as a consequence of): 2 attending Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed by newy à 2 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Deen has **DAGE 2** 250 No 1 Tyes 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidance 8 Other (Specify) 1 Yes 25 No 2 min 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. injury at Work? Certification: Athar 5 Pending invastigation Naturat 1 ☐ Yas 2 ☐ No death. 2 Accident alter deal 3 Suicide 6 Could not be datarminad 28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Straat end Number or Rural Route Number, City or Town, Steta) 4 Homiclda To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and piaca, and due to the cause(s) and mannar as statad.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, daath occurred at the tima, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b Gignature and title of certifier 29c. License number 11elleene 36 Name and address of person who complated cause of death (Item 23a) (Type, Print) LAWRENCE D. BOHAN, M.D., 606 DUTCHMANS LANE, EASTON, MD 21601 31. Data filad (Month, Dey, Year) 32. Registrar's Signature State

Registrar

SEP



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Laurie P. Ventry Sept. 5, 1998 A.K.A Larry 10:10AM 4a Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Suburban Hospital Bethesda Montgomery | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) | Sept. 2, 1919 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Months Deys 1⊠M 2□ F Yrs. 090-18-5842 Italy 79 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11405 Orleans Way 20895 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Stetus Black, Whita, etc. 1 XYes 2 No if Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 □ Widowed 4 □ Divorced WWII White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Television/ Elementery/Secondery (0-12) College (1-4or 5+) Electronics Small Business Owner 4 18. Mothar's Neme (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Paul Ventry Caroline Unknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Barbara B. Ventry (wife) 11405 Orleans Way, Kensington, MD 20b. Place of Disposition (Name of cametery, cramatory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 9/10/98 Peekskill, NY 4 ☐ Donetion 5 ☐ Other (Specify) Assumption Cemetery 22. Name and Address of Fecility Francis J. Collins Funeral 21. Signature of Funeral Service Licensee Home, Inc. 500 University Blvd. West Silver Spring, MD Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 20901 Approximate Intervel Between Onset end Deeth Immediate Causa (Final SEPSIS 1 mm fx diseese or condition resulting in deeth) Due to (or es e consequence of): Cellulitis Due to (or es e consequenca of): Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceusa (Disease or injury thet initiated events resulting in deeth) Last peripheral Unscular disease Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 1 No 3 Probably 4 Unknown atherosclerotic heart disease 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy 1 Yes 2 No 1 TYAS 2 No. 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) Hospitel: 1 Anneatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Panding

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Physician/Medical à Completed Be Jo L Certification:

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permit. Pages 1 and 2 sh Depertment of Health end Important: If item 27 is m any injury or other traum pncs.

Physician /Medical

Examiner

should be f

the Maryland

72 hours efter death

ゴル Baltimore, Maryland 21215-0020

27. Menner of Deeth 1 Natural 2 Accident 3 ☐ Suicide

29a. Cartifian

(Check only one)

investigation 6 Could not be determined 4 Homicide

1 Yes 2 No

28e. Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and true of certifie

29c. License number 035103 29d. Date signed (Month, Day, Year) geptember 6, 1998

30. Name and addrass of parson who complated cause of deeth (Itam 23a) (Type, Print)

6240 Montrese Rel Rockille MD 20852 Stephen Vaccare 332

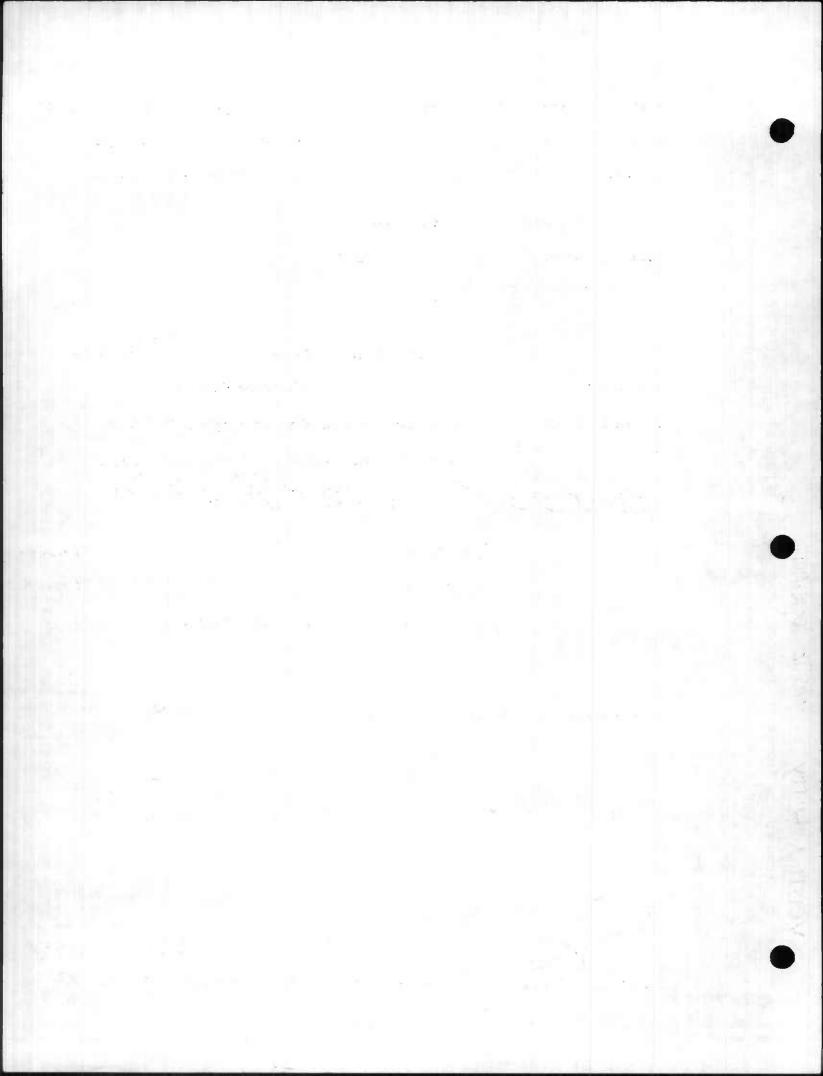
State Registrar

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31. Dete filed (Month, Day, Year) SEP 0 8 1998 32. Ragistrer's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1998 Alexander Volonts Sept. 3, 3:58pm 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Montgomery General Hospital 01nev Montgomery | H Under 1 Yaar | H Under 24 Hrs. | 8. Date of Birth | 9. Birthplace | Months | Days | Hours | Min. | Aug. | 22, 1912 | Russia 9. Birthplace (Steta or Foreign 7. Age (In yrs. lest birthday) 1₩ M 2□ F 143-24-7341 86 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8610 Mayfair Place 20910 USA 14. Race - Americen Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yas 2√☐ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Broker Banking 17. Fethar'a Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Sumeme) Janis Volonts Alvine (unknown) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Patricia Volonts-spouse 8610 Mayfair Place Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burlal 2 ☎ Cremation 3 ☐ Removal from State Long Island Cremation Co. 9-10-98 West Babylon, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Sarvice Licenter 22. Name and Address of Facility Danzansky Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville MD 20852 11.1. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediate Ceuse (Final disease or condition resulting in deeth) MYOCARDIAL INFARCTION Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediata ceusa. Enter Underlying Cause (Disease or injury that Initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Tounknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Matural 5 Pending 1 Yes 2 No investigation 2 Accidant 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)

The law requires that the deeth certificate be executed physician and the buriel-tran Division of Vital Records, P.O. Box 68760 Se USB signed by t peed certificate Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: Aftar this certifica director, funeral

Physician

/Medical

Examiner

MD

Directo

Funeral

by

Completed

Funeral

Director

with the Maryland

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any hjury or other treumatic event, the Medical Examiner must be notified at once.

Physician /Medical

Examine

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

altimore, Maryland 21215-0020

25. Was cese referred to medicel examiner:

4 Homicide

29a. Certifie

29b. Signa

6 Could not be determined

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

d title of certifier 29c. License number M.O., OME

015236 OME

29d. Date signed (Month, Day, Year) September 6, 1998

30. Name and address of person who completed ceusa of death (item 23e) (Type, Print)

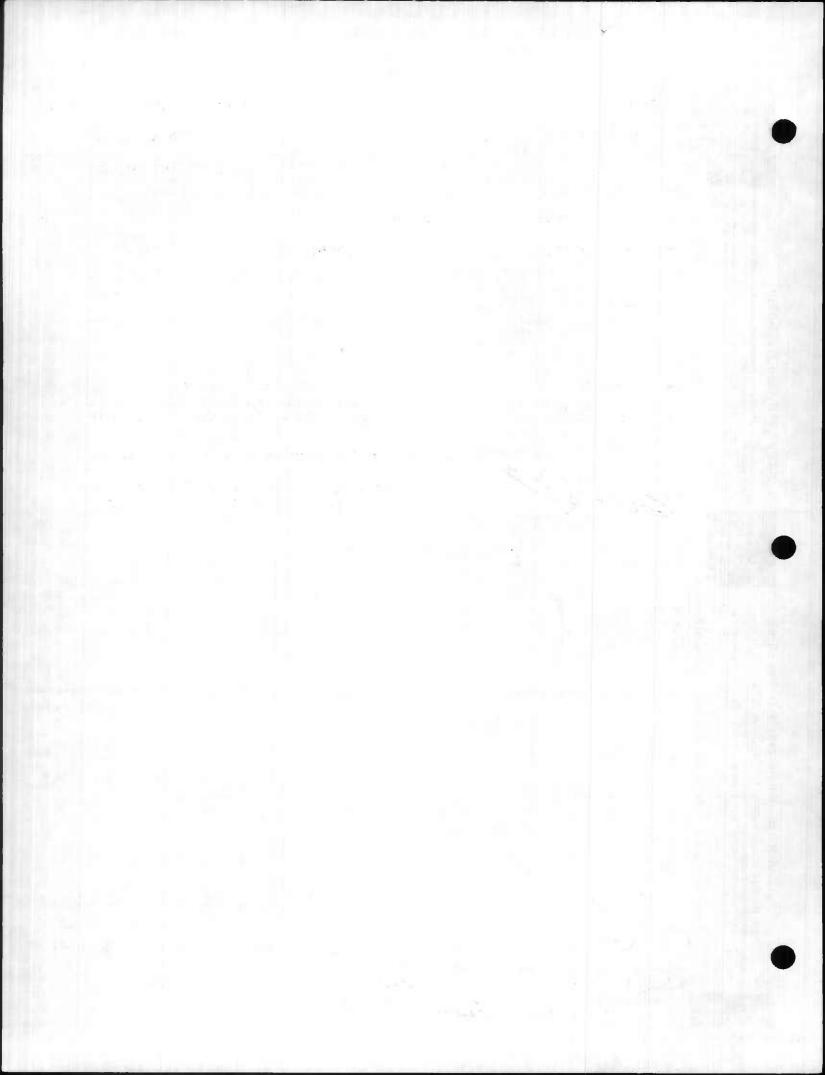
MO. 11/25 POCKUIUT PIKE, POCKUIUE, MO 20852 MARGOY,

31. Date filed (Month, Day, Year) State SEP 0 8 1998 Registrar

32. Registrar's Signeture

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) September 2, 1998 Wendell Frederick Witt 8:30 A.M. 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not Institution, give street end number) Adelphi If Under 1 Year | ff Under 24 Hrs. Prince Georges 9303 Lynmont Street 8. Dete of Birth 9. Birthplece (Ste April 20,1911 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) Months Deys Hours XM 2 F 87 Yrs 577-20-0105 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits XYes 2 No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7105 Sycamore Ave. U.S.A. 20912 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien 11. Maritel Status Bieck, White, etc. XYes 2 □ No If Yes, Give Yeer or Dates: 1 Never Merried XX Married 1 Yes 2 XNo Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Painter Painting Company 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) August Witt Beryl Spence 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Iillian S. Witt/wife 7105 Sycamore Ave. Takoma Park, MD 20912 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 XCremetion 3 Remove from State 4 Donetion 5 Other (Specify) Virginia Crematory Sept. 3,1998 Arlington, VA 22. Name end Address of Fecility Takoma Funeral Home, Inc. 21. Signature of Funerel Service Licenses ecau 254 Carroll St. NW Washington, DC 20012 Part Educate disease or complications shock or heart favore. List only one ceus list caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) 4 years Alzheimer's Disease Due to (or es e consequence of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10e. Stete

Directo

Funeral

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Completed

Be

Funeral

Director

ir than "natural", or items 23s or 28s-f show the Medical Examiner near be notified at

with the Maryland

death

filed within 72 hours after

Hygiene.

other is marked other

permit. Pages 1 and 2 should be file.
Department of Health and Mantal Hy
Important: If Nem 27 is marked oth
any linjury or other traumatic eventpage.

Baltimore, Maryland 21215-0020

attending physician and for use as the bunal-transit The law requires that the death certificete be executed

Box 68760.

Division of Vital Records, P.O.

Physician:

or Attending

Examiner

Physician/Medicai

by

Completed

Be

2

Certification:

edicai

29a. Certifier

(Check only one)

ed by the a signed certificate has been si eged After this funeral s after deam.

Due to (or es e consequence of)

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specifical Regiver

1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

28c. Injury et Work? 1 Tyes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

24a. Wes en eutopsy performed?

1 Yes

28d. Describe how injury occurred

2X MIO

🖄 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier

29c. License number D22309

29d. Dete signed (Month, Dey, Year) September 3,1998

23b. Did tobacco use contributa to the causa of death?

1 Yes 2 No 3 Probably 4 ♥ Unknown

24b. Were autopsy findings available prior to completion of cause of deeth?

1 Tyes 2 No

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Philip W.Roth, MD 9013 Flower Ave. Silver Spring, MD 20901 31. Dete filed (Month, Day, Year)

State Registra

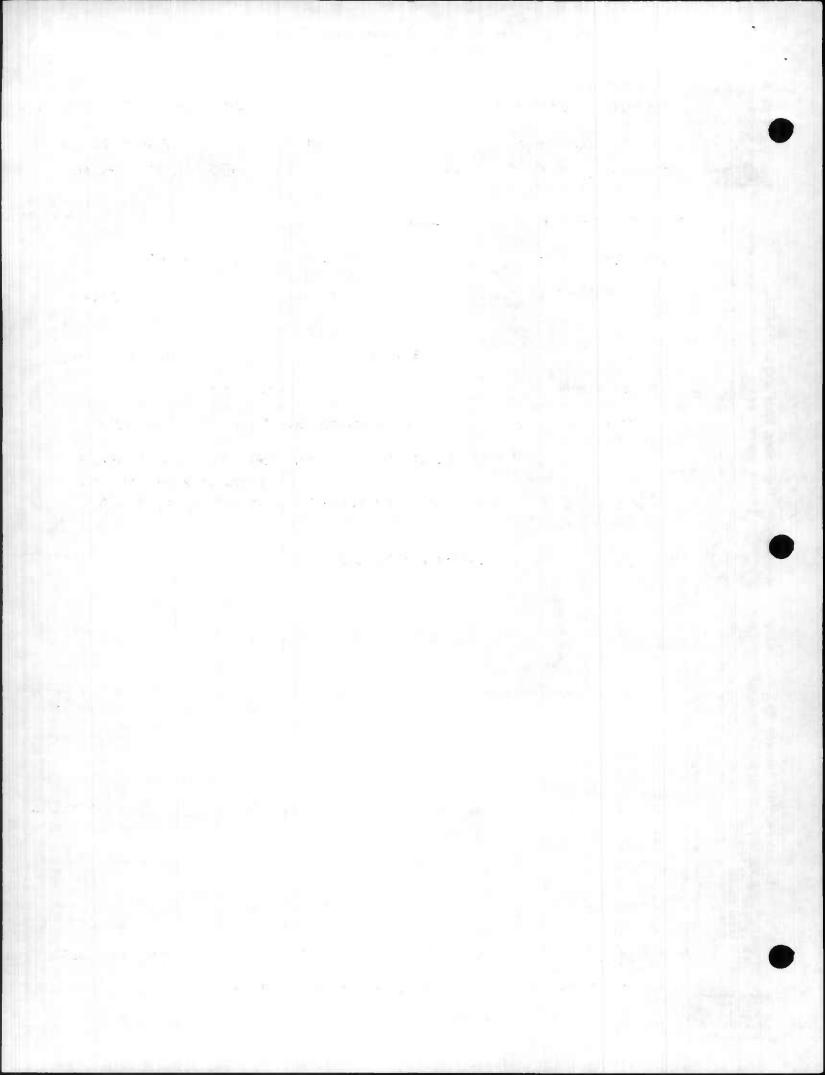
SEP 1 0 1998

32. Registrer's Signeture

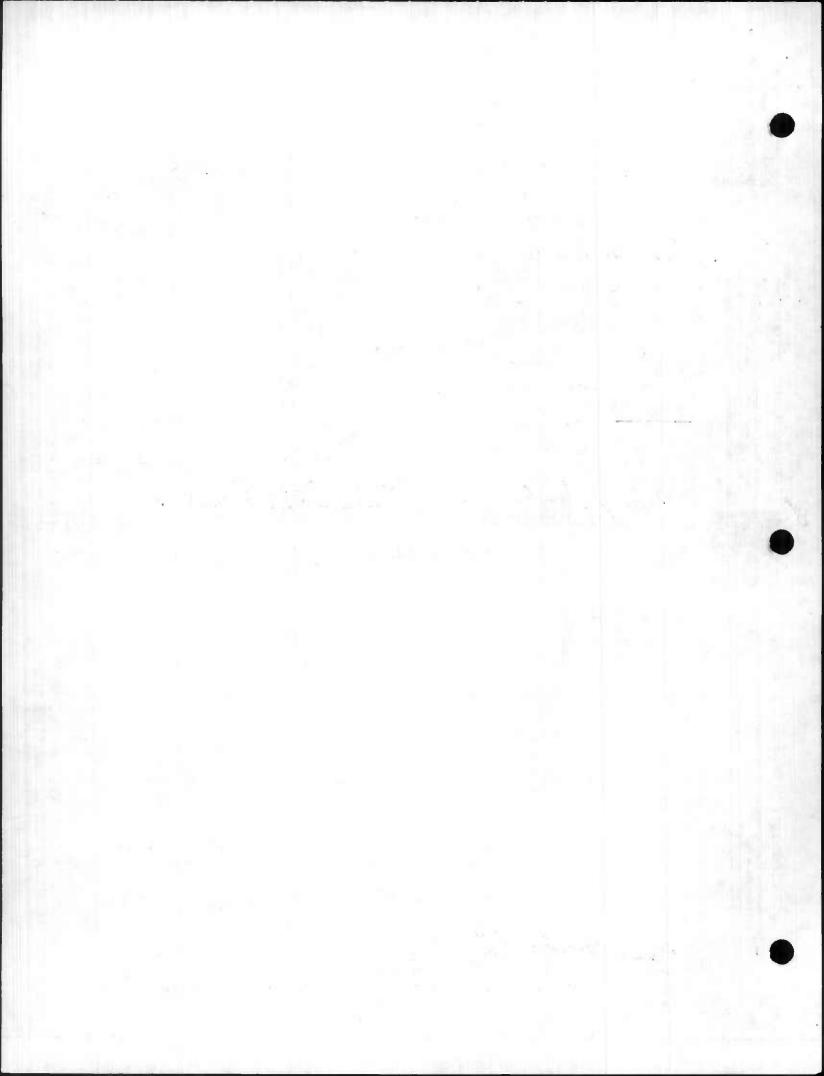
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Funeral Director	5. Social Security Number None Usual Residence of Decede		M 2□ F		s. last birthday,	Months	Days	Hours	Min.	8. Dete of Birt (Month, Da Nov. 4,	y, Year) 1914		intry)	te or Foreigr
Para Maria	10a. State 10b. C			10c. 0	City, Town or L	ocation							10d. Insid	e City Limits
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23a c	20015 Swee	tgum (ircle #	14		20	874				Chin	a		
Roma Darm	11. Marital Status		12. Was Deced	dent Ever in	U,S. 13.	Was Deced	lent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	14. Re	ce - Amer	ican Indiar	١,
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Maryland 21215-0020 d 2 should be filed within 72 hours et in end Mente lygiane. 7 te marked other than 'natural', or treumatic event, the Medical Energy than the filed Energy	3 Widowed 4 Div		Year or Dai	tes:	10- P	death Here	10	-Alan				Cn	inese	2
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D High	15. De (Specify only) Elementary/Secondary (CO) 17. Father's Name (First, M	iddle, Last)			_!			18. Mothe	er's Nem	e (First, Middle,	Meiden Sume	me)		
ld be lented the dic ev	Not Avai	lable						No	t Av	ailable				
re, Maryland 3 1 and 2 should be filed Health and Mental Hyg tem 27 te marked other other treumatic event,	19a Informant's Name/Rel Kuang-Hua We Kuana hua We	ationship (T)	pe, Print)		19b. Mail	ng Address	(Street	end Numbe	er or Rur	al Route Numbe	er, City or Town	, State, Z	ip Code)	
md 2 mg 27 th	Ruant Hua We	n/Son						n Cir	cle i	14, Ger	mantown	, MD	208	174
mit. Pegas 1 am partment of Heal portant: if New 2 y Injury or other	20a. Method of Disposition 1 ☐ Burial 2 ☑Crema	ation 2 DE	lamaval from C		Place of Disponentery, cre	osition (Nen metory or o	ne of ther plec	e)Sept	. 12	Dale 998	20c. Location	- City or T	own, State	9
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Baltimore, Misperit Pegas 1 and 2 Department of Health e Important: if item 27 te eny injury or other treamer.	21. Signatupe of Funeral Se	Fan	ee	MOO	198 R	Name and Dert	Addres	umph umph iontg	rey omer	Funeral y Avenu d 2085	Home/R	lockv	ille,	Inc.
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Physician /Medical Examiner	Immediate Cause (Finet disease or condition resulting in death)			Fract	ure of	Cervi	cal	III					3 da	ys
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Division of Vital Records, P.O. Box 687 or Attending Physician: The law requires that the daeth cartificeta after daeth. Director: After this certificate hes been signed by the ettending phys in by the funeral director, page 2 should be datached for use as the											an autopsy med?	C	Vere autopoutelle prompletion of death?	osy findings for to of cause
The is	E									10	Yes 2⊠No	1	☐ Yes	2 No
an: riffica rifor, p	25. Was case referred to m	edical						26. Place	of Deat	h (Check only o	ne)			
Vision of Vita Attending Physician: offer: After this certific by the funeral director.	examiner? 1 Yes 2 No	I	lospital: 1 🖾 In	patient 2	☐ ER/Outpatie	nt 3 DC	A Oth	er: 4 Nu	ursing Ho	ome 5 Resid	dence 6 🗆 Ot	ther (Spec	city)	
O de Parente de Parent		Pending	28a. Date of	Injury , Day Year)	28b. Time of	1 2	8c. Injun Worl	y et k?		28d. Describe	ale-later and			
Mendir Agent.	2 Accident	rvestigation	Sept. 3	3, 1998	3 23:00	P M	10	Yes 2⊠			Down St	-		
DIVISION ARTON SILVEN ARTON DIRECTOR	3 Suicide 6 C 4 Homicide	could not be letermined	28e. Place o	of Injury - At g, etc. (Spec	home, farm, st	reet, factory	, office			28f. Location (: City or To	Street end Num vn, Stete)	<i>ber</i> or Ru	ral Route I	Vumber,
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DIV To the Hospital or A within 24 hours after To the Funeral Dire complately filled in E	(Check only 2 Me			is of examin						and due to the red at the time,				se(s)
To the Tour Comp	29b. Signature and title of c	ertifier	1	1	1	290	. License	e number			29d. Date sign	ed (Month	o, Dey, Yes	ar)
1	1	-	3/11	4	10	3	D070	99			Septemb	er 6	, 199	8
	30. Name and address of po	erson who co	ompleted cause	of death (Ite	em 23a) (Type	Print)								
	Francis C. M					ernwoo	d Ro	oad,	Beth	esda, M	aryland	1 20	817	
State				distrer's Sig		1	.,	,						
Registra	SEP 1	T 1998	1	Partie	D.	1000	eks	/						



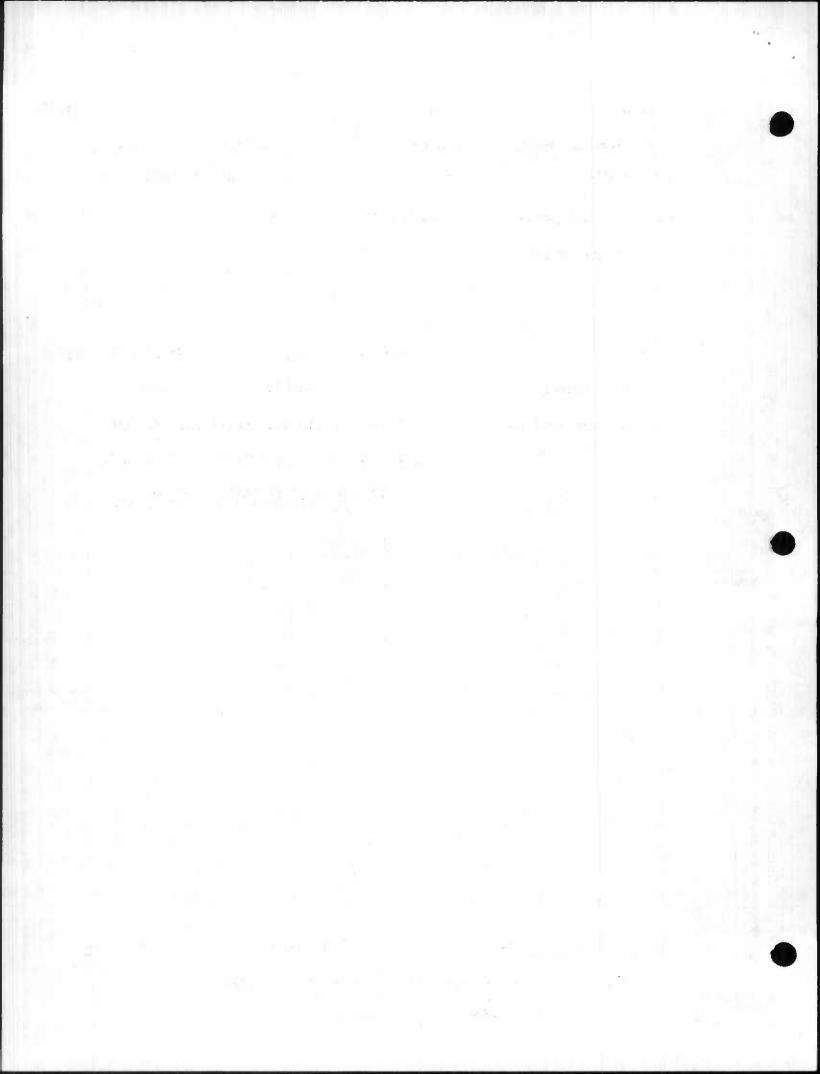
State of Maryland / Department of Health and Mental Hygiene [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Year 31, Aug. 1998 3:30PM Werner Anna /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 6. Sex 1 ☐ M 2 ☐ ¥F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days 92 Yrs. Director 056-10-8404 NY July 7, 1906 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examinal must be notified at Rockville Md. Montgomery Director 1 Yes 2 No 10e. Street end Number 10f, Zip Code 10g. Citizen of Whet Country? 6121 Montrose Rd. 20852 US Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 X Never Married 2 Married 1 ☐ Yes 2 ☐No if Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within Department of Health and Mentel hygiene. Important: If Item 27 is marked other than 'r any Injury or other traumatic avent, the Health Industrial or other traumatic avent, the Elementery/Secondary (0-12) College (1-4or 5+) Jewelry Assembly Jewelry Factory 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Wineberg Elias Werner Sophia 0 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Werner/Niece 506 Great Falls Rd. Rockville, Md. 20850 20a. Method of Disposition 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriai 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Mt. Lebanon Cemetery 9/2/98 Iselin, Nj 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md.

23a. Part1. Enter the disease, or completions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, 20852 Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final CEHOVASCULAR Acc ident disease or condition resulting in death) 6 Wars Examiner Due to (or as a consequence of): Examiner Ltype tension YRI the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical Due to (or es e consequence of): 98 ettending 0 Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? sate has been signed by pege 2 should be detec 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Piace of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 XNo this 27. Manner of Death 28a. Date of injury (Month, Dey Year) To the Hospital or Attending Pt within 24 hours effer deeth.
To the Funeral Director: After the completely filled in by the funera Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Watural thours effer deeth.

'uneral Director: Af
ely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 023958 50 9, 1988 30. Name end address of person who completed cause of death (item 23a) (Type, Print)

1.2. M. Wust Rd. Roch IV 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State SEP 09 1998 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Sept. 7, 1998 4:00am Frieda Wachsman 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Mediplex of Montgomery Village Montgomery Gaithersburg 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 10M 28F Yes. 118 50 5212 90 12-14-1907 NY 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes SENO Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19301 Watkins Mill Road 20886 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 245 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 Yes all No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working Me. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Callege (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Wexler Pauline Granick 19th. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type, Print) Harriot Adler/daughter 8820 Thomas Lea Terrace, Montgomery Village, MD 20b. Place of Disposition (Name of cylimetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3XX temoval from State 5 Other (Specify 4 Donat Ararat Cemetery 9-9-1998 Farmingdale, New York 21. Signature of inera Service 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel, Inc. 1170 Rockville Pike, Rockville, MD 20852 the death. Do not enter the mode of dying, such as cardiac or complications that cau Interval Between Onset and Death allure. List only one cause on eac ediate Cause (Frase or condition iting in death) UBBRACHMO (1) HEMORRHAGE 2 WEEKS Due to (or as a consequence of): Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 20€No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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Director

r than "natural", or items 23e or the Medical Exerniner must be r

id 2 should be fill and Mental Fill is marked of treumstic even

permit. Pages 1 and 2 at Department of Health and Important. If them 27 is n any Injury or other treus

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Examiner burial-tran physician 9 # 980 2 È 8 page 2 certificate has a a

Physician/Medical ğ Completed Be To Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I.

24a. Was an autopsy performed? 1 Yes 2 No

GROVE RO Rakulk

completion of cause of death? 1 ☐ Yes 2 KNo

25	Was case referre	d to medical						26.	Place of De	ath (Check only one)
	examiner? 1 ☐ Yes 2 ☑ N	0	Hospital:	1 ☐ Inpatient 2 ☐	ER/Outpatient	3[]	DOA Oth	E 4	Nursing P	fome 5 ☐ Residence 6 ☐ Other (Specify)
27	Manner of Death 1 KNatural 2 Accident	5 Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	м	28a. Injury Work		2 🗆 No	28d. Describe how injury occurred
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286.	Place of Injury - At h building, etc. (Speci	nome, farm, stree	rt, fact	tory, office			281. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

tion Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

cause of death (Item 23s) (Type, Print) 15225

JHADY

State Registrar

edical

1 0 1998

32. Registrar's Signature

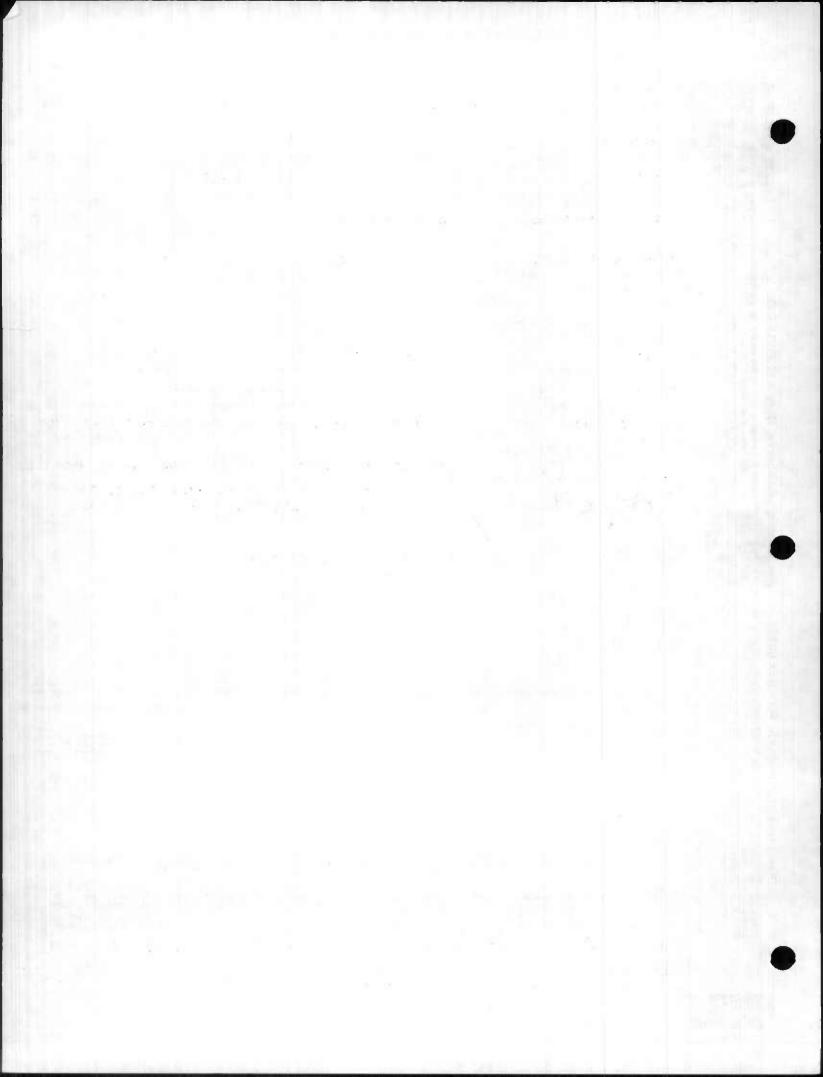
After

or Attend after deat Director:

Within 2 To the ŝ

Hospital 24 hours

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	#26,	9/1	1/98,BMW,	Montgome	cy Count	у.	C	ertifica	te of	Death		Reg. No.	96	29120
20	Phys	ician	200	me (First, Middle, L							2. Date of D Sept.	oath O3ay	1998	3. Tima of Death 8: 22AM
	/Me	dical		M. Walt		mhasl				4b. City, Town, or			unty of Death	
	Exar	niner		(II not institution, g							EGGRIOTI OF EGG			
-	Funer	al l	5. Social Security		Sex DRI	7. Age (In yrs	. last birthda		r 1 Yea		8. Date of B		VTGOMEI 9. Birth	X I place (State or Foreign intry)
ı.	Direct		075.12.6 Usual Residence	0400	1 M 2□ F		78 Yrs.		Days	s Hours Min.	8. Date of B (Month, D 05/12/	1920	BRO	OKLYN, NY
	with the Maryland a or 28a-f show	_	10s. Stete	10b. County		10c. C	ity, Town or	Location						10d. Inside City Limits
	23a or 28a-f ehor	Director	NY	NASSAU		WI	LLIST	ON PAI				10- 02:	1 May - 1 Co.	1 Yes 2 No
	with a or		10e. Street and N					101. 21	p Code	11400			n of What Cou SA	intry ?
	deeth deeth	Funeral	67 TUL	LP LANE	12. Was Dece	edent Ever in U	J.S. 1	3. Was Dece	dent of	11496 Hispanic Origin? (S	Specify Yes or N		Race - Amer	ican Indien,
0		F		rried 2 Married	Armed Fo	orces? 2□Noww ve		If Yes, spe	cify Cu	ban, Mexican, Puer	to Rican, etc.)		Bleck, White	, etc.
00	hours after ural, or its	l by	3 🖫 Widowed	4 Divorced	Year or D	ates: Prm	1	1 🗆 Yes	2LANG	Specify:		Sį	pecify: WI	HITE
5-0	2 24	Completed	(Spe	15. Decedent's lecify only highest g			(Gi	cedent's Usu	ork don	e during most of wo	rking	16b. Kind	of Business/I	ndustry
121	within jiene. r than	E E	Elementary/Sec	condary (0-12)	College (1	1-4or 5+)		DO NOT						
9			17. Father's Name	(First, Middle, Las	4		1 00	RPORA	EE	18. Mother's Na	me (First, Middle		OIL & (AS
Maryland 21215-0020	s 1 and 2 should be filed f Health end Mental Hyg tem 27 le marked other other traumstic evant,	To Be	ABRAHAM	WALTER						HELEN "	UNKNOWN	THI .		
ary	2 should be ond No.	_	19a. Informant's f	Name/Relationship	(Type, Print)		19b. Me	eiting Addres	s (Stree	et and Number or R	ural Route Num	ber, City or T	own, State, Z	ip Code)
	and 2 saith e n 27 le		ELISSE V	VALTER/DA	UGHTER					DOMINION	DRIVE,	BETHES	SDA MAI	RYLAND 2081
ore			20a. Method of Dis	sposition	YRemoval from		Place of Dis cemetery, o	sposition (Na cremetory or	me of other pi	lace)	Date	20c. Loca	tion - City or T	own, State
Ë	Pag ment lant: I			5 Other (Spec		BE	TH IS	RAEL C	EME	TERY	9/4/98	NEW 3	JERSEY	
Baltimore,	permit. Page Department of Important: If any injury or		21. Signature of F	uneral Service Inc	insee					ress of Facility gel Funer	al Dire	ction.	INC.	
_ 6.	703 e		1/2	1				1091 H	Rock	ville Pik	e, Rock	ville,		
June .			23a. Parti. Enter shock, or he	the disease, or con art tallure. List only	nplications that c y one ceuse on e	eused the dea each line.	th. Do not	enter the mo	de of dy	ying, such as cerdia	c or respiratory	arrest,		Approximate tntervel Between Onset and Death
	Physicia Medic/		Immediete Cause	(Final									t	
	Examin		disease or conditi resulting in death	ion)	a. META	ASTATIC							<u> </u>	8 MONTHS
П.		Je L				Due to (or as e com	sequence of						
	tificate be executed grant and as the burial-trensit	amln	Sequentially list of	onditions,	b	Due to (or as a con:	sequence of)):					7
ó	e exe	Ex	Sequentially list of if any, leeding to cause. Enter Und Cause (Disease of	immediate derlying										
68760,	certificate be rding physicia use as the bur	dica	thet initiated even resulting in death)	IS .	С	Due to (or as a cons	sequence of)	:					
9 ×	ding b	Me			d			1						
Box	death of attended for us	clan									1		- !	
P.O.	iras that the death certifications is gned by the attending does detached for use as	Physician/Medical	Part II. Other sign	ificant conditions	contributing to de	eath but not re	sulting in the	e underlying	cause g	given in Part I.		Yes 2		to the cause of death obably 4 DUnknow
	s that the ned by the e detache	by P									,,,	7105 20	NO 3071	South 4 South low
rd	v requires been sign should be		1 T. Y								24a. Wa	s an autopsy lormed?	24b. V	Vere autopsy findings vailable prior to
00	2 s b	Completed							-		, ,			ompletion of ceuse f death?
- m	0 - 0	Com									1□	Yes 2 🖫	No 1	☐ Yes 2☐ No
/ita	ysicien: The s certificate director, per	Be (25. Was cese refe examiner?	erred to medical							ath (Check only			3
of o	5 00	10	1 □ Yes 250		1		ER/Outpat		UA	ther: 4□ Nursing I				daughter's
Division of Vital Records,	Ing After	lon:	27. Manner of Dea	5 Pending		ot Injury th, Dey Year)	28b. Time Injur	e of y M	28c. Inj	uryet ork? ⊒Yes 2 ⊒No	28d. Describe	now Injury (occurred	
Sic	deeti deeti	Certification:	2 ☐ Accident 3 ☐ Suicide	investigati	be ge Diese	ot Injury - At h	home farm				28f. Location	(Street and I	Number or Ru	ral Route Number,
	after Direct Jin by	=	4 ☐ Homicida	determine	buildi	ng, etc. (Speci	ify)	Jiloot, Jacob	y, omo			own, State)		

30. Name and address of person wito completed cause of deeth (item 23a) (Type, Print) Dr. Fred Smith, 5401 Western Ave. Washington, D.C. 20015

State Registrar

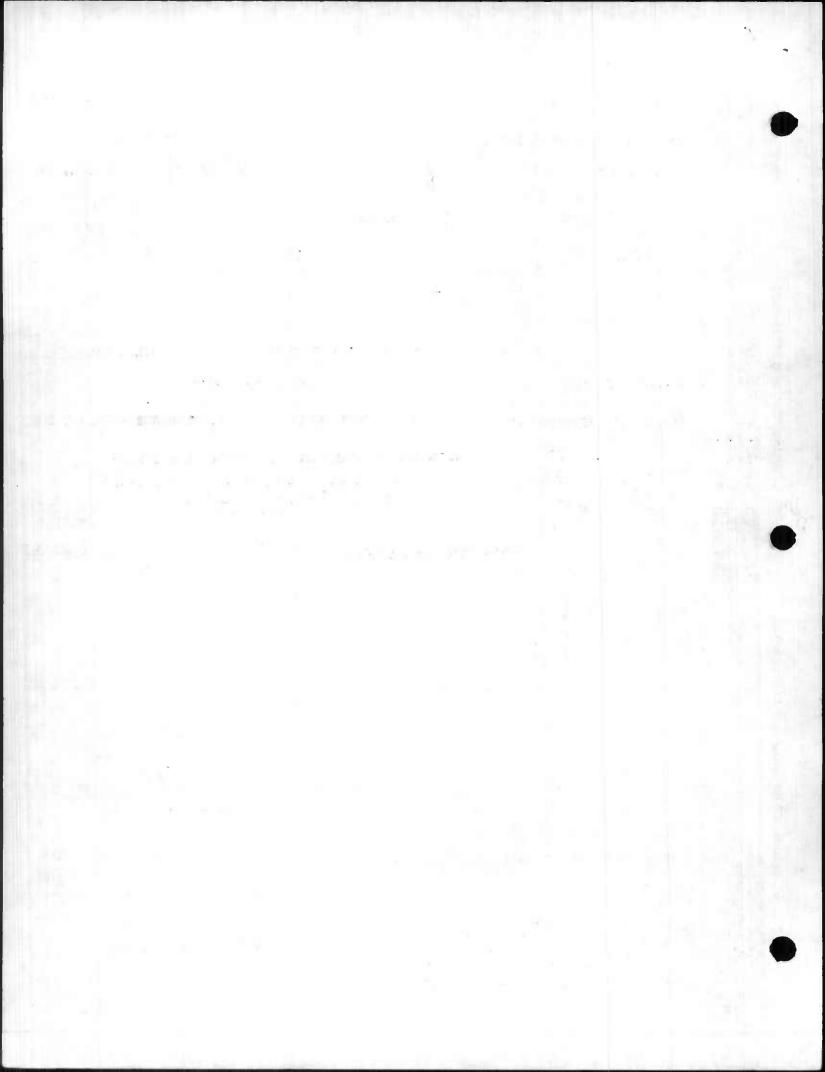
29b. Signature and title of con-

31. Date filed (Month, Dey, Year) SEP 1 0 1998

32. Registrar's Signature

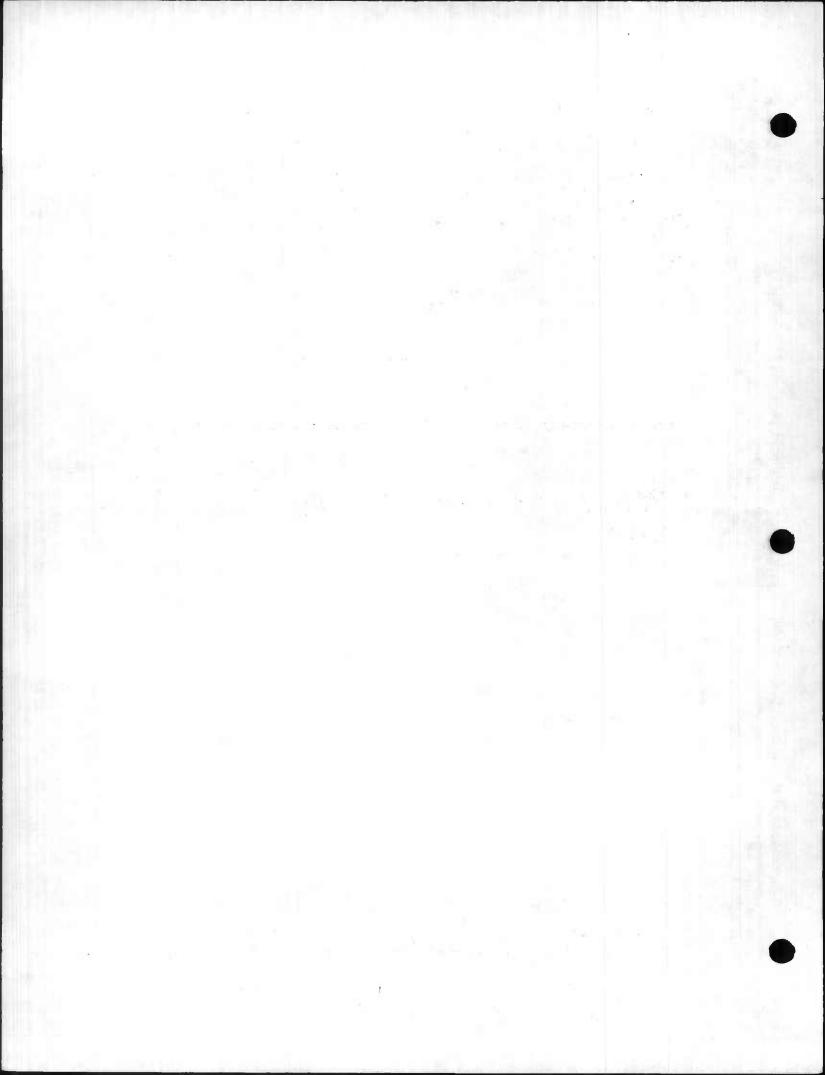
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State of Maryland / Department of Health and Mental Hygiene 98 29 | 2 |

					Certific	ate of	Death			Reg. No.)	.3121
		1. Decedent's Neme (First, Middle, Li	ist)						2. Dete of De	eth	Mari	3. Tima of Deeth
	Physician	James Dennis Watt	terson					S	Month Septembe	Dey r 5, 1998	Year	10:55 PM
	/Medical Examiner	4e Facility Name (If not institution, gi			-		4b. City, Tov		ation of Deat			10.55 111
ľ		Manor Care-Chevy	Chase				Chevy	Chas	e	Mont	gomer	cv
	Funeral	5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last bii	rthday) If Ur Mont	nder 1 Year	If Under a		8. Dete of Bir (Month, De			place (Stete or Foreign
п	Director	065-22-8357	1⊠M 2□F	70	Yrs.	Deys	riours	J	uly 12,	1928		York
	p ,	Usuet Residence of Decedent		10a City Tau	!ti							0.1
	anyla athoy	10a. Stata 10b. County		10c. City, Tow							,	1 ☐ Yes 2 No
	or 28s-f a	Virginia Fairi	ax	Burke								
	Dir.	10e. Street and Number			101.	Zip Code				10g. Citizen of V		
	72 hours after death with the Maryland natural, or thems 23s or 28s-1 show dies Escales must be notified as ted by Funeral Director	6104 Winnepeg Dri			1.0.11	22015		1 0 10	· · · · · · · · · · · · · · · · · · ·	United		
	the man	11. Maritel Status	12. Was Decedent Armed Forces?		13. Wes De	specify Cub	an, Mexican	gin? (Spec , Puerto R	cify Yes or No tican, etc.)	Btec	a - Amano k, White,	can Indian, etc.
20	by F	1 Never Married 2 Merried 3 ☑ Widowed 4 □ Divorced	1 K Yes 2 □ I If Yes, Give		1□ Ye	s 2⊠No	Specify:			Specify	. Whi	ite
S	natural,	15. Decedent's E	Year or Detes:	1948	Decedent's I	level Occur	ention			16b. Kind of Bu		
L U		(Specify only highest gr	ade completed)		. Decedent's U (Give kind of life. DO NO	work done	duning most	of working	9	100. Killa of Ba	13111033/1110	udstry
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Maryland 21215-0020	EIDE A	17. Father's Neme (First, Middle, Last)	Į IIC	-count_	LACCO	T	r's Neme	(First, Middle	, Meiden Sumem		•
lan	7 2 6 8 8	James J.	Was	tterson			Anna	Sul1	ivan			
ary	2 should and Men la marke eumatic	19e. Informent's Neme/Reletionship	(Type, Print)	198	o. Meiling Add	ress (Stree	t end Numbe	er or Rural	Route Numb	er, City or Town,	State, Zip	Code)
	nd 2 lith a 27 le r tre	Jean A. Watterson	1/ Daughte	r 61	04 Win	nenee	Drive	e. Bu	rke. I	Virginia	2201	15
Baltimore,	of Health a fram 27 le train other train	20a. Method of Disposition		20b. Plece o	f Disposition (Neme of	ocal -		Dete	20c. Location -		
OH	20 = 2	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		Montgo	omery (remat	Septe	mber /	, 1998	Bethesd	a. Ma	arvland
=	pemit. Pag Department Important: I eny Injury o	21. Signature of Funeral Service Doe										neral Home/
ä	Per	Dell /	7	mood								nsin Avenue,
		23a Part I From the disease or con		1 the death Do	1		Bethes	sda.	Mary1a	and 2081	4-350) 1 Approximate
4	Dhysisian	23a Part Menter this disease, or con thock, or heart tallers. List only	one cause on each li	ne.			g, caa cc		roopo.o.y c			Intervel Between Onset and Death
	Physician /Medical	Immediate Cause (Finel	34	1. 1 7 6								
N.	Examiner	disease or condition resulting in death)	a. Myocard	dial Inf								
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	axecuted in and rial-transit		b. Atheros	Due to (or es e			Diseas	se			1	
ć	axec in any isl-tri	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury		Due to (or es e	consequence	Oi).						
68760,	rificate be assocuted to physician and as the burial-transit Aedical Examir	trial initiated events	C	Due to (or es a	consequence	ot).					-	
68		resulting in death) Last		200 10 (0, 00 0.	0011004001100	0.7.	,					
Box	at the death certi d by the attending etached for use a Physician/M		d								1	
	es that the death cer igned by the attendir be detached for use by Physician/A	Pert II. Other significant conditions	contributing to death b	ut not resulting i	n the underlyir	no cause oi	ven in Pert t.		23b, Dld	tobacco use co	ntribute to	o the cause of death?
P.O.	by the		199	•					120	Yss 2□ No	3 □ Prof	bably 4 Unknown
	es that igned be defended by P	Head & Neck Canc	er									
Records,	requires that the seen signed by th hould be detache eted by Phys								24a. Wes	an autopsy	24b. W	era autopsy findings vailable prior to
00	> 10 00								peri	ormed r	CO	ompletion of cause deeth?
R	The la								10	Yes 2 No	15	☐ Yes 2☐ No
Vital	ificat or, p	25. Wes case referred to medical					26 Piece	of Death	(Check only			3100 23.10
>	Physician: The lav this certificate has ral director, page 2 ral Grector, page 2.: To Be Comp	examiner? 1 ☐ Yes 2 ☑ No	Hospitel:	ant 2 DER/O	utpatient 3	DOA Ot	hor:			idenca 6 DOth	er (Snecil	fv)
o	rthis eral di	27. Menner of Death	28a. Dete of Inju	ry 28b.	Time of	28c. Inju		-		how injury occur		"
O	offing th.: Afte fun	1 ☑Netural 5 ☐ Pending 2 ☐ Accident investigation	(Month, De	y Year)	Injury M		ork?]Yes 2∐!	No				
Division	tal or Attanding P is after deeth. al Director: After tied in by the funeral Certification:	3 Suicide 6 Could not b	286. Piece of in	ury - At home, fe	erm, street, fed	ctory, offica		2		Street and Numb	er or Rure	al Route Number,
ă	d in d	4 Homicide	building, et	c. (Specify)					City of 10	wn, Stete)		
	spltument ners y fille		nysician: To the best									
	he Hospit in 24 hour he Funer pletely fill	(Check only 2 Medical Examone)	miner: On the basis of and menner sto		d/or investiga	tion, in my	opinion, deet	th occurre	d at the time,	date end pteca,	and dua to	o the cause(s)
	To the Hospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	29b. Signeture and little of certifier				290 Licen	se number	10		29d. Dete signe	d (Month,	Dey, Year)
	7+1	/ ho	1 h	rec		1)	354	56	2	Septeml	202	6, 1998
		30. Name and address of person who	completed cause of c	leeth (Item 23a)	(Type, Print)	0				septem	JET	6, 1998
		Lila T. McConnell				010	Chevy	Chac	o Man	w1 and 20	Q1 E	
	State	31. Dete filed (Month, Day, Year)		er's Signeture	1	1	MEVY	ondsi	rial .	y Lanu ZU	יירדטיי	
	Pogietrar	CED 0 9 100	10 Marie	was .	14 1	no u	,					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Sept. 4, Mary H. Weedon 1998 8:40AM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Kensington 3216 Fayette Road Montgomery If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1 □ M 2 🗓 F Yrs. 83 Aug. 24, 1915 **Director** 213-38-2000 Virginia Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show with fulry or other traumatic event, the Madical Examinet must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3216 Fayette Road 20895 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Š 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health Care Registered Nurse 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) To Charles C. Holland Martha Morse 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 22485 Margaret W. McDaniel (daughter) 10018 Gera Road King George, Virginia 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 9/8/98 Rockville, Maryland 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

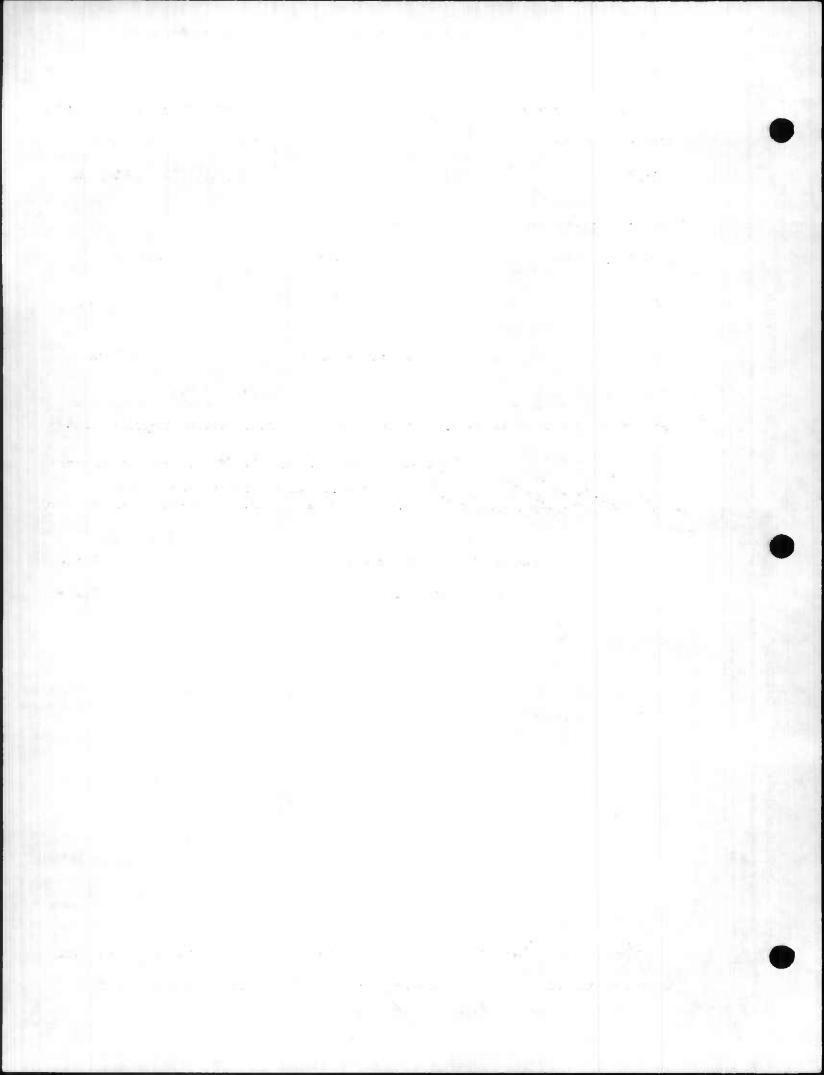
Enter the dhone, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

Approximate Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) a Congestive Heart Failure Years **Examiner** Due to (or as a consequence of): Examiner b. Coronary Heart Disease Years attanding physician and for usa as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o the 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ے signed t Diabetis Mellitus Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en autopsy performed? peen page 2 s has 1 ☐ Yes 2 ₩ No 1 ☐ Yes 2 ☐ No certificata Physician: director, Be 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residenca 8 ☐ Other (Specify) 10 1 Tyes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this 28e. Date of Injury (Month, Dey Yeer) 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? Certification: Hospital or Attending 5 Pending 1 X Naturel n 24 hours after death.

• Funeral Director: After the function of the functin 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 150 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and menner stated. 29a. Certifier edical pletaly (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) annex in 15 an ash D 06019 September 4, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harris M. Kenner, M.D. 5454 Wisonsin Avenue Chevy Chase, Maryland 20815 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State SEP 0 8 1998 Registrar

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth SEPTEMBER 7, 1998 **Physician** HELEN LOUISE WEGA 9:28 PM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Suburban Hospital Bethesda Montgomery 8. Dete of Birth (Month, Day, Year) Dec. 9, 1925 9. Birthplece (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Min 1□ M 21X F Yrs. 229-22-1090 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, In Mesters Example must be notified an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Germantown 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 늄 United States 20874 19001 Perrone Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White ò 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Bryant Lena John King 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19001 Perrone Drive, Germantown, Maryland 20874 William P. Wega, Sr./Husband 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, Stele 20e. Method of Disposition 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State Parklawn Cemetery 9/11/98 Rockville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility
Muriel H. Barber Funeral Home 21. Signeture of Funeral Servica Lice P.O. Box 5038, Laytonsville, Maryland 20882 GAMA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervei Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner rabates Mellitus requires that the death certificate be executed attending physician end for use as the burial-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es e consequence of): Due to (or es e consequence of) resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Fallure - chronic Kenal þ 24b. Were eutopsy findings evelleble prior to 24a. Wes en eutopsy performed? Completed peen completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No certificate director, 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 12 Inpatient 2 □ ER/Outpetient 3 □ DOA this 28e. Dete of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: After 5 Pending Investigetion or Attending 1_Netural n 24 hours after death.
he Funeral Director: After a principle of the funeral principle of the f 1 ☐ Yes 2 ☐ No 2 Accident

Helen L. Waga 9/7/98 928pm To the F

Registrar

To the Fune completely fi

29b. Signature and title of cartifier

6 Could not be determined

SEP 1 0 1998

3 Sulcide

29a. Certifler

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4 Homicide

(Check only one)

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and menner staled.

29d. Dete signed (Month, Dey, Year) September

28f. Location (Street end Number or Rural Route Number, City or Town, State)

, Lockville

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

809 Veirs Mill

Holden M.D. David 31. Dete filed (Month, Dey, Yeer)

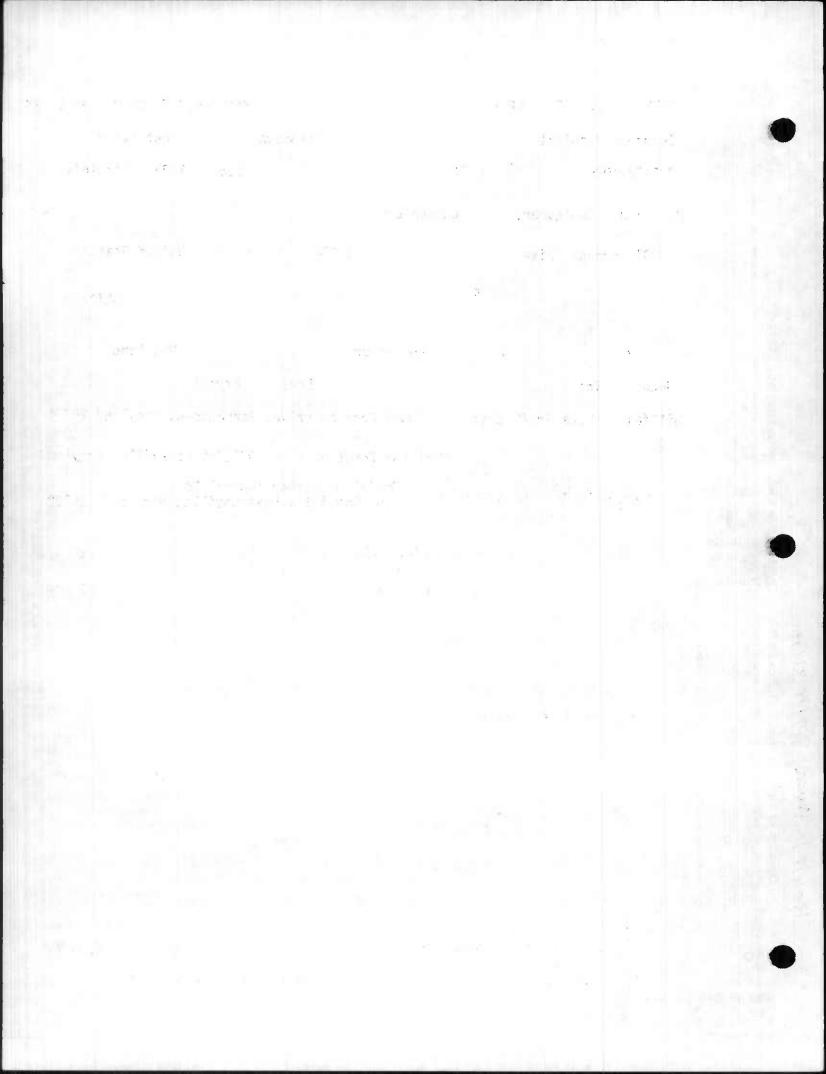
32. Registrer's Signeture

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

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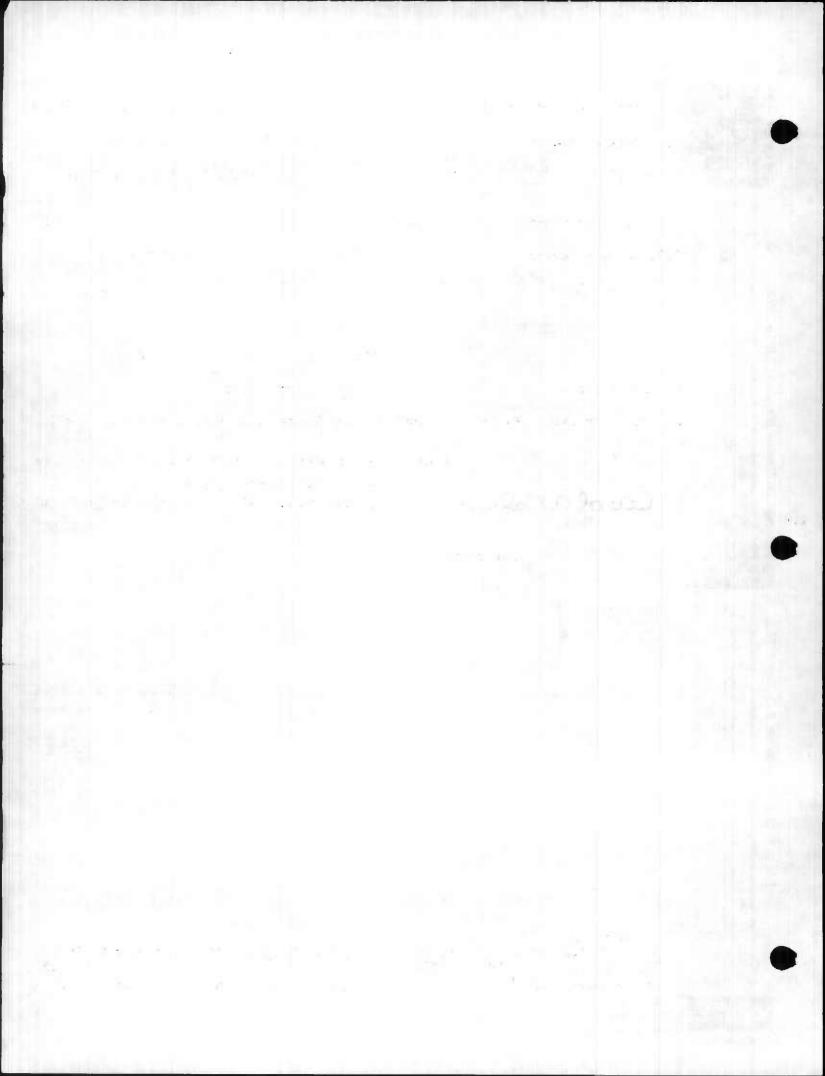
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State of Maryland / Department of Health and Mental Hygiene

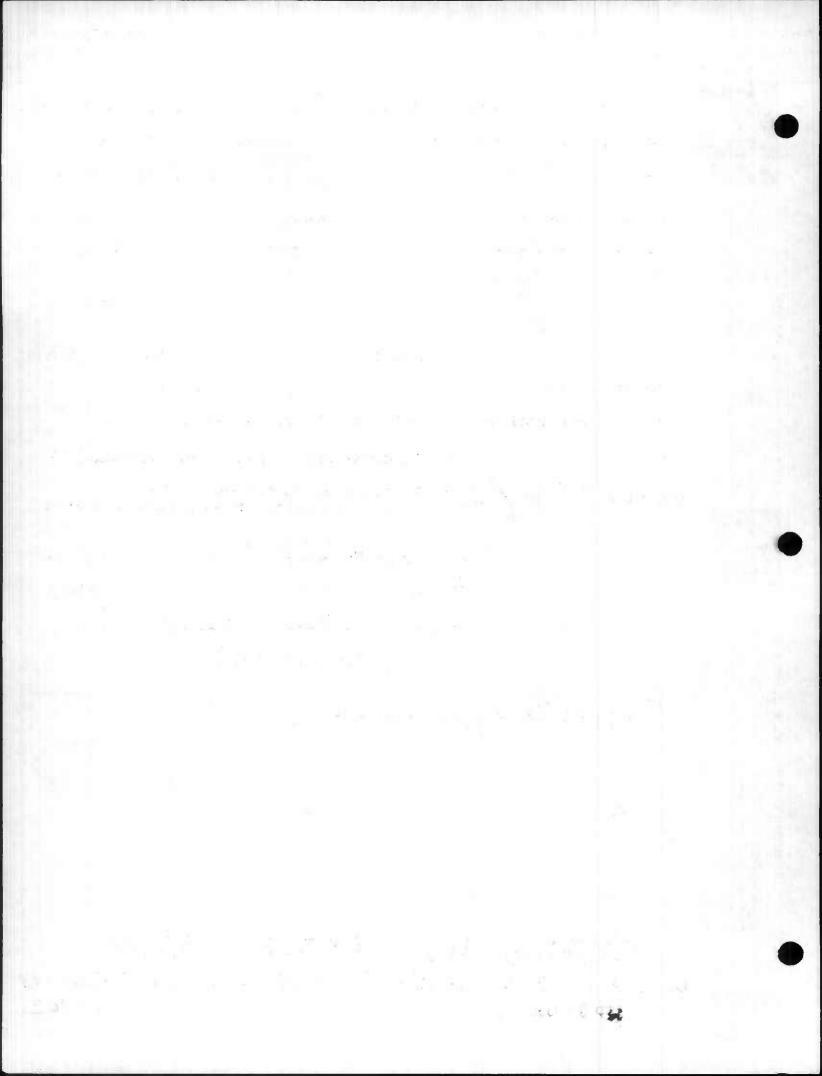
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Funera Directo		5. Social Security Number 6. S 579-46-5699 Usual Residence of Decedent	Sex 7. Ag	e (In yrs. lest b	Yrs.	Months Days		(Month, D	8, 1909		laca (Steta or Foraign try) York
land wa		10a. State 10b. County		10c. City, To	wn or Loc	ation				10	0d. Inside City Limits
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumetic avant, the Medical Example must be notified.	by Funeral	11. Marital Status 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 \(\) Yes 2 \(\) If Yes, Giva Yaar or Dates:			/as Decedent of Yes, specify Cul ☐ Yes 2 1 No	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or N to Rican, atc.)	0- 14. Rec Ble Specify	e - Americ ck, White, v: Wh	
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s aft self in Dia		v									
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completally filled in by the funer	edicai	29a. Certifier 1 ☐ Certifying Pt (Check only one) 1 ☐ Medical Example 1	ysician: To the best on niner: On the basis of end menner sta	exeminetion e	ge, death end/or inve	occurred at the sastigetion, in my	time, dete and plec opinion, deeth occ	e, end due to the urred at the time	e ceuse(s) and m a, dete and plece,	anner as si end due to	rated. the ceuse(s)
To the To the comp	Z	29b. Signature and title of certifier				29c. Licer	nse number		29d. Date signe	d (Month,	Dey, Year)
10		114	cep	70		0	262	59	Septemb	er 8	, 1998
10		30. Name end address of person who	completed cause of d	eath (Item 23a) (Type, P	rint)	-				20814
		Ava Kaufman, M	.D.	14.000		4930	Del Ray A	venue,	#403, Be	thes	da, MD
	tate	31. Date filed (Month, Dey, Year) SEP 1 0 19	32. Registr	ar's Signatura	1						
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth **Physician** Month September 5, 1998 WENTZEL 3:55 A.M. Dorothy Jeannette /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Northampton Manor Nursing Home Frederick Frederick | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 25, 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Maryland 1 M 25 F 79 1919 Director 214-10-5407 Usuel Residence of Decedent the Meryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at Frederick Frederick 1 Yes 2 □ No Director Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? items 23a or 21701 U.S.A. 200 East 16th Street Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black. White, etc. 1 Yes 2 No If Yes, Give X Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married ŏ Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White "natural". Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementery/Secondery (0-12) College (1-4or 5+) Manafacturing Company 9 Hygie Assembler permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othe any injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Leslie G. Gross Elsie G. Heffner 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8610 Myersville Rd., Middletown, MD 21769 William Adrian Wentzel/Son 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete He Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Olivet Cemetery 1998 Sept. 9, Frederick, MD 21. Signature of Funeral Servica License 22. Name end Address of Fecility Keeney and Basford Funeral Home M00021 106 East Church Street, Frederick, MD 21701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory shock, or heart feliure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse /Final disease or condition resulting In death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed ettending physician end for use es the buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Box 68760. Due to (or es e consequence of): noperable Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. the be deteched 23b. Did tobacco use contribute to the cause of death? Yes signed by 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? peed hes certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 35 No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA After this 28e. Dete of Injury (Month, Dey Year) Certification: 27. Magner of Deeth 28d. Describe how injury occurred 28c. Injury et Work? Neturel 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours efter death Funeral Director: / 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) à 4 - Homicide Hospital Cartifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier Medical completely (Check only within 2 \$ 29b. Signature and title of ce 29c. License number 29d. Dete signed (Month, Day, Year) 0 ause of deeth (Item 23e) (Type, Print) HOWAR TENTINEW DR. FIREDERICK MY 21702 State Registrar



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Q Month **Physician** blember 3 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19302 RESH MILL ROAD HAMPSTEAD BALTIMORE 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) NOV 29,1910 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 N 2 □ F Months Days Hours 87 Yrs MARYLAND 218-20-3014 **Director** Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inaide City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at HAMPSTEAD 1 ☐ Yes 2 ☑ No Director MARYLAND BALTIMORE 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 19302 RESH MILL ROAD 21074 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo Black, White, etc. nit. Pages 1 end 2 should be filed within 72 hours after rentment of Health end Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Nei Plulyr or other traumatic event, tra Medical Examina 1 Never Married 2 Married If Yes, Give Year or Dates: 1 Yes 2 XNo Specify: WHITE Specify. þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) UNKNOWN 10 UNKNOWN 18. Mother's Name (First, Middle, Meiden Sumema) 17. Father's Name (First, Middle, Last) HUGH WRIGHT WALLIS, SR BERTIE WILLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 490 PROSPECT RD, WARMINSTER, PA 18974 META B. DAY, NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of important: If any injury or HAMPSTEAD, MD HAMPSTEAD CEMETERY 9/8 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility 21. Signature of Funeral Service Licenses ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 70SC Examiner Due to (or as a consequence)of) Examiner 35 physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 80 esn ō ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Whiknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? certificata has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Presidence 1 Dres 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐ Other (Specily) After this funeral 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 DNatural 5 Pending investigation death. 1 Yes 2 No 2 Accident or Attendatiant after deati filled in by the 6 Could not be determined 28f. Location (Street and Number or Rurel Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

29d. Data signed (Month, Dey, Year)

State Registra

29b. Signature and title of certifier

31. Date filed (Month, Dey, Yeer)

SEP 0 8 1998

s of person who completed cause of death (Item 23a) (Type, Print) yne//M

32. Registrar's Signature

with the Merylend

death

Maryland 21215-0020

Baltimore,

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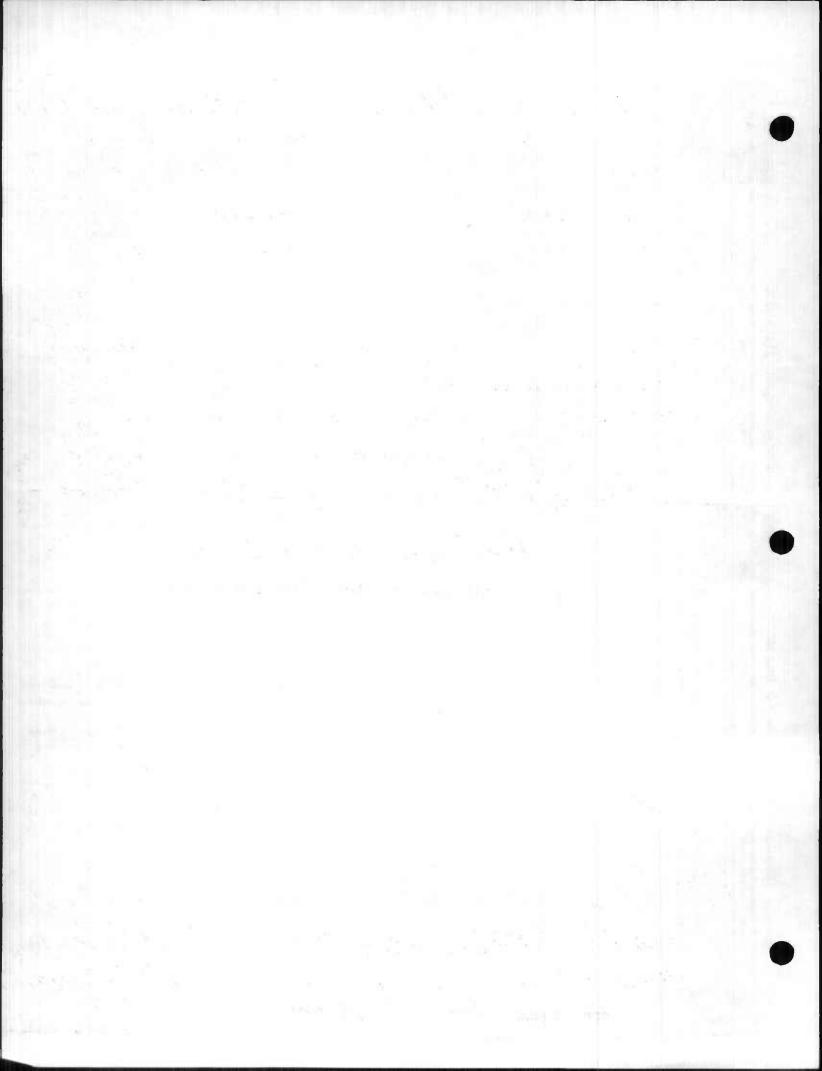
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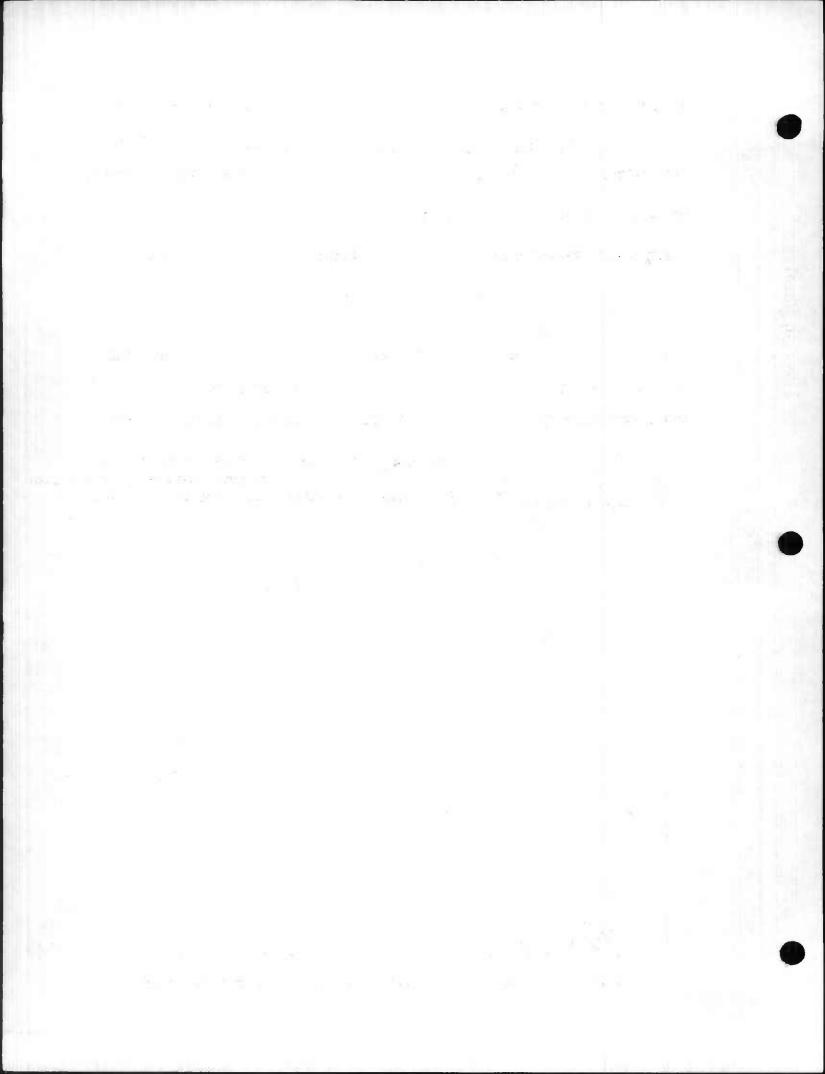
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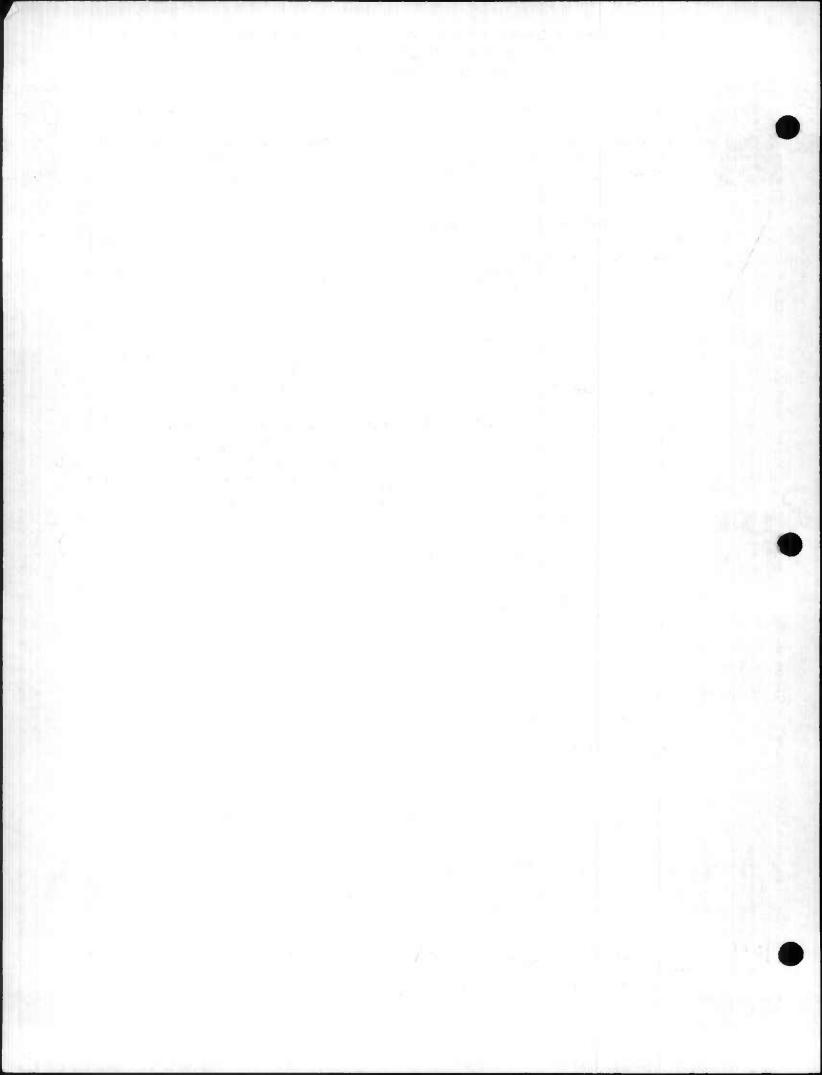
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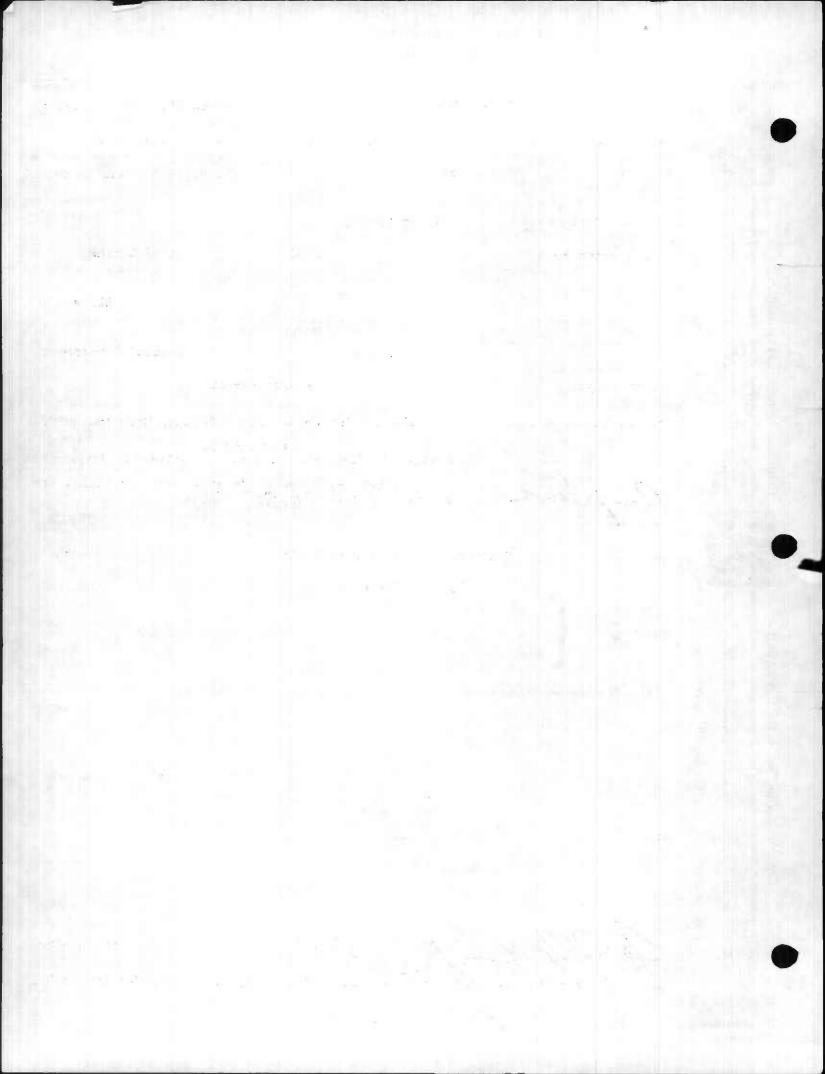


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/Medical		Jean B. Youn	ıg		4b. City, Town, or t	August	31, 199		1:45 PM
Examiner	4e Facility Nama (If not institution, giver Holy Cross Hosp				Silver Sp		h 4c. County of		v
Funeral Director	5. Social Security Number 6. S			thday) If Undar 1 Yaa Months Dey	r If Under 24 Hrs.	8. Data of Bi (Month, Di Feb. 5	rth ay, Year)	9. Birthpl	lace (Stata or Foreign try) ington, DC
Pu *	Usual Rasidanca of Dacedant 10a. Stata 10b. County	10c. (City. Town	n or Location				110	Od. Insida City Limits
Manyle of aho	Maryland Montgom			r Spring					1 □ Yas 2 No
or 28s	10e. Street and Number			10f. Zip Code			10g. Citizan of W	hat Coun	try?
ath wi	4516 Bennion Roa				20906		United S		
filed within 72 hours after death with the Maryland Hygiene. Hygiene then "natural", or items 23s or 28s-f show ant, its Medical Examine must be notified at e. Completed by Funeral Director	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedant Ever in Armed Forcas? 1 □ Yas 2 ☒ No If Yas, Giva Yaar or Datas:	U,S.	13. Was Decedent of If Yas, specify Cu 1 ☐ Yes 2 ☒ N		pecity Yas or No o Rican, etc.)	Specify:	, Whita,	an Indian, etc. iite
72 ho	15. Decedant's Ed (Specify only highest gra	ducation	16a.	Decedant's Usual Occ	upation a during most of wor	kina	16b. Kind of Bus	inass/Ind	lustry
be filed within 72 houtst led other than "natural other than "natural event, the Modical Be Completed	Elemantary/Secondary (0-12)	Collega (1-4or 5+)	Ro	(Giva kind of work don lifa. DO NOT usa reti okkeeper	red)		Foderal	Cov	ernment
filed v Hygie other t	17. Fathar's Nama (First, Middla, Last,)	ВО	okkeeper	18. Mother'e Nan	ne (First, Middle	, Maiden Sumama		ernment
2 should be end Mental Is merked o summit eve	Robert Bunyea				Audrey H	Richards	3		
shou end N a mar	19a. Informant's Name/Ralationship (. Malling Addrass (Stra					
and	Harry E. Young/Hu			16 Bennion					
permit. Pages 1 and 2 should be filed within 72 hours aft Depertment of Health and Mental hygiene. Important: If Item 27 is merked other than "natural; or any injury or other traumatic event, its Medical Exampages. To Be Completed by F	20a. Mathod of Disposition 1 □ Burlal 2 ☑ Crametion 3 □ 4 □ Donation 5 □ Other (Specif	Ramoval from Stata	camatar	Disposition (Name of y, cramatory or other pomery Crema	torium, I	nc.	Bethesd	a, Ma	aryland
Depending Support	21. Signature of Funeral Service Licer	1	0198	Robert A. 300 West Rockvill	ress of Facility Pumphrey Montgomen e, Marylan	Funeral vy Aveni nd 208	L Home/Ro 10 50-2805	ckvi	lle, Inc.
Physician	23. Part I. Entar tha disaasa, or com shock, or heart failura. List <i>on</i> ly	plications that caused tha da ona causa on aach lina.	ath. Dor	not entar tha moda of d	ying, such as cardiac	or raspiratory	errest,		Approximata Intarval Batwean Onset end Death
/Medical Examiner	immediata Causa (Final disaasa or condition rasulting in daath)	a. Carcinoma	a Met	astatic to	Brain				Months
	Taboning in duality	Probable		consequence of):				1	Months
cuted nd transit	Sequentially list conditions,	b		consequence of):					110110110
law requires that the death certificate be executed as been signed by the attending physician end by 2 should be detached for use as the bunal-transit appleted by Physician/Medical Examiner	Sequentially list conditions, if any, laading to immadiata causa. Entar Undartying Causa (Disaasa or Injury that Initiated avants rasulting In daath) Last	cDua to	(or as a c	consequence of):					
death certifie attending ad for use a sician/Me	Part II. Other significant conditions of	dontributing to death but not re	asulting Ir	tha undariying causa	givan In Part I.	23b. Did	tobacco use con	tribute to	the cause of death?
hat the de od by the a detached Physic						10	Yes 2□No	3 ☐ Prot	bably 4½ Unknown
The law requires that the death cert cate has been signed by the attending page 2 should be detached for usa Completed by Physician/M						24a. Was	s an autopsy ormed?	OOI	ara autopsy tindings ailabla prior to mpletion of causa death?
0 - 0 -						10	Yas 2⊠No	10	Yes 2□ No
certificata rector, pa	25. Was casa rafarrad to medical axaminar?	Harastell .			26. Place of Dea	ath (Check only	ona)		
his his	1 ☐ Yas 2 ☒ No 27. Manner of Death		ER/Ou	tpatient 3 DOA			idance 6 Otha		0
ding it. Aftar funer	1 ☑ Natural 5 ☐ Panding 2 ☐ Accidant Invastigation	28a. Data of Injury (Month, Day Year)	200.	njury W	ork? □ Yas 2 □ No	200. 5000155	now injury occurre	, ,	
Hospital or Attending Physician: 24 hours after death. Funeral Diractor: After this certificately filled in by the funeral director.	3 Suicida 6 Could not b datarmined	28a. Place of Injury - At building, atc. (Spa-		rm, streat, factory, offic	е	28f. Location City or To	(Street and Number own, State)	or or Rura	l Routa Number,
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After toompletely filled in by the funeral Medical Certification:		ysician: To tha best of my ki niner: On tha basis of axami and mannar statad.							
To the within	29b. Signature find title of castuler	15	DE .		nse number		29d. Data signed Septen		Day, Year) 1, 1998
	30. Name and addrass of person who John J. Merendir		Country of the Countr	Type Poin 1 Randolph		6, Rock	ville, Ma	aryla	and 20852
State Registrar	31. Data filed (Month, Day, Year) SEP 0 8 19	32. Registrar's Sig		G. Spar					

Registrar DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene

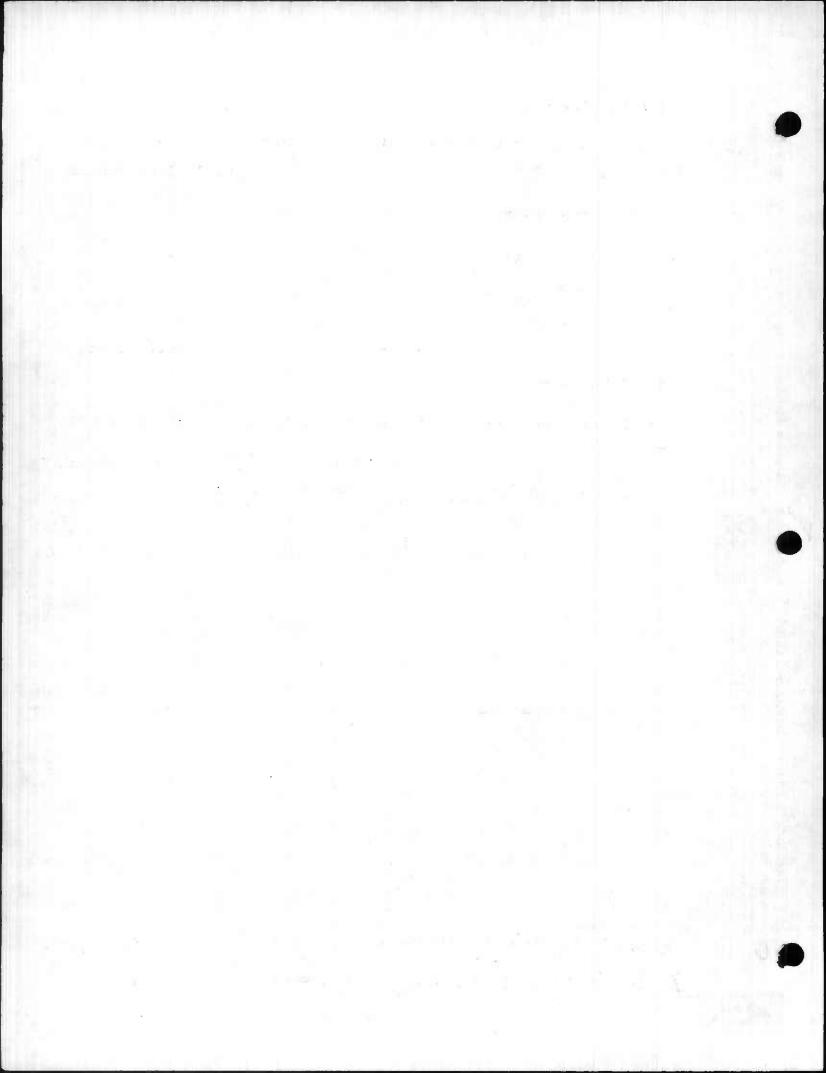
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Ida May Zeskind Sept. 6, 1998 3:15pm /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ater Washington

7. Age (In yrs. last birthday)

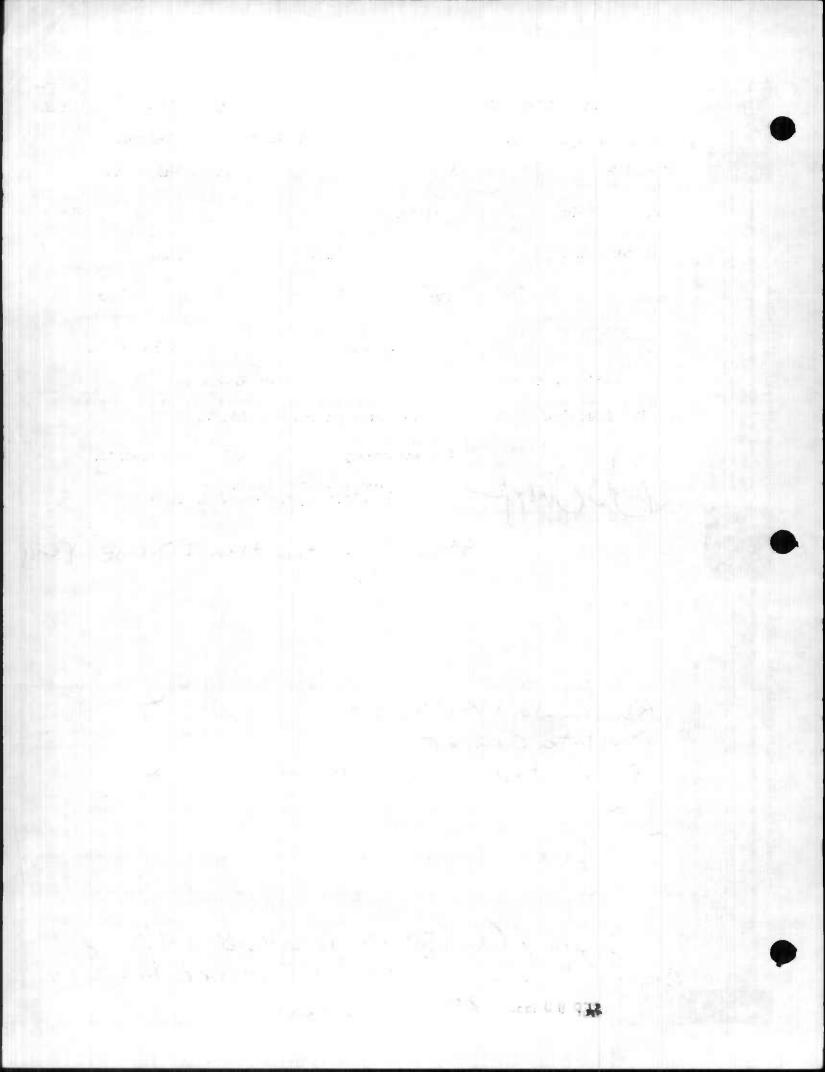
| If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | 9. Birthpleca (State Months | Deys | Hours | Min. | Jan. 17,190 | 9. Birthpleca (State Months | Deys | Hours | Min. | Jan. 17,190 | 9. Birthpleca (State Months | Deys | Hours | Min. | Jan. 17,190 | 9. Birthpleca (State Months | Deys | Hours | Min. | Jan. 17,190 | 9. Birthpleca (State Months | Deys | Hours | Min. | Jan. 17,190 | 7. Birthpleca (State Months | Deys | Hours | Min. | Jan. 17,190 | 7. Birthpleca (State Months | Deys | Hours | Min. | Jan. 17,190 | 7. Birthpleca (State Months | Deys | Hours | Min. | Jan. 17,190 | 7. Birthpleca (State Months | Deys | Hours | Min. | Jan. 17,190 | 7. Birthpleca (State Months | Deys | Hours | Min. | Jan. 17,190 | 7. Birthpleca (State Months | Deys | Deys | Months | M Hebrew Home of Greater Washington 5. Social Security Number 6 Sax **Funeral** 9. Birthpleca (Stata or Foreign 1 M 2 X F Director 577-26-2345 Usual Residence of Decadent the Maryland 10e State 10b County 10c. City, Town or Location must be not find at 10d. Inside City Limits Maryland Montgomery Bethesda Director 1 X Yes 2 □ No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? with 7500 Westfield Dr. 20817 U.S.A. Funeral death 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Yaar or Dates: r than "natural", or itams Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Bleck, White, etc. filed within 72 hours effer 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 Yes 8€ No Specify: þ 3- Widowed 4 Divorcad Specify: White Completed 15. Decadent's Education 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Peges 1 end 2 should be filed withir Department of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, If a Me Elementery/Secondery (0-12) College (1-4or 5+) Real Estate 12 Salesperson Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Israel Denaburg Frieda Zachkin 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 7500 Westfield Dr. Bethesda, MD Thelma Lourie/Daughter 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) King David Mem. Gdns. 9/10/98 Falls Church, VA 21. Signature of Funerel Servica Licanse 22. Name end Address of Fecility Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, VA 22201 23e. Pert1. Enter the disaase, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory arrest, shock, or heer failure. List only one cause on each line. Approximeta Intervel Between Onset end Death **Physician** PNEUMONIA BOTH LOWER LOBES /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate causa. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest the buriel-trer Due to (or es a consequenca of): Box 68760, ettending physician Physician/Medical Due to (or es a consequança of): signed by the et P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown VASCU LAR Division of Vital Records. þ should b 24b. Were eutopsy findings avaliable prior to completion of cause of death? Completed 24e. Wes an autopsy certificate has b lirector, page 2 s 2X No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Teffer death.

Director: After this certifications Be 25. Wes case referred to medical examiner? 28. Plece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA P 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Panding 1 Weturel 1 Yes 2 No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, straat, factory, offica building, etc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and placa, and due to the cause(s) and menner as stated.

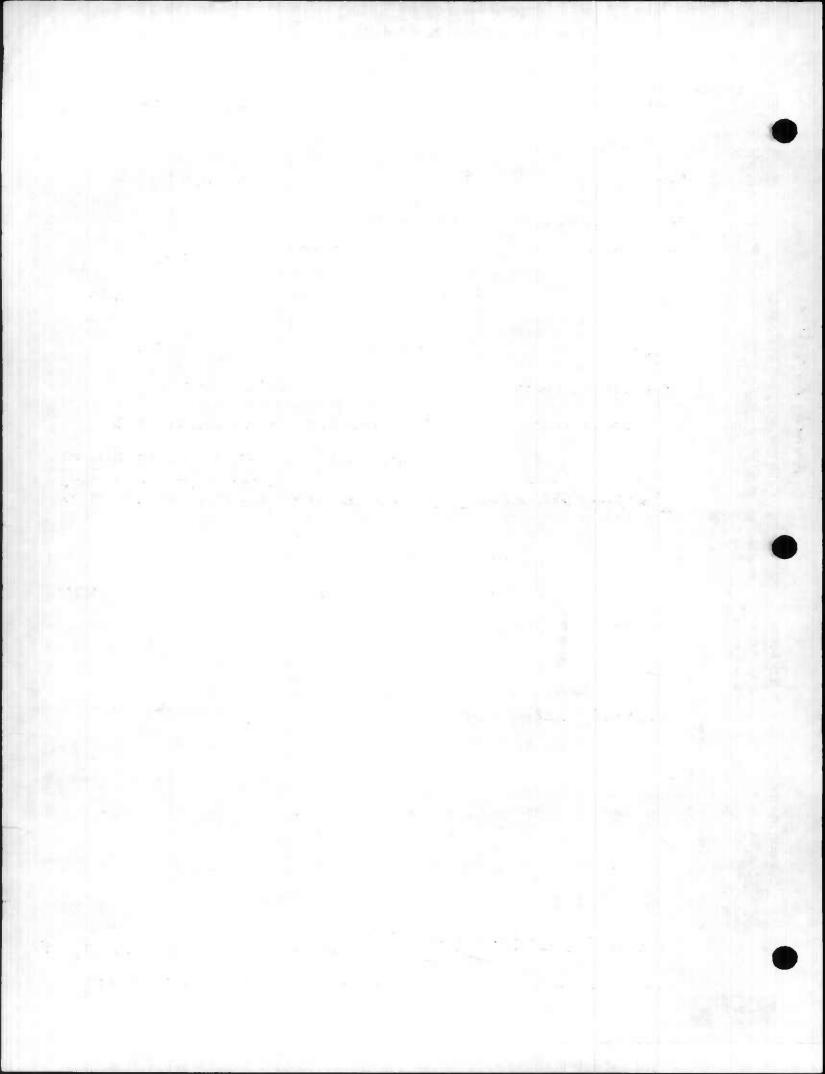
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data end place, and due to the cause(s) and menner stated. edical 29a. Certifier To the Hosp within 24 hou To the Fune completely fi 29b. Signeture and title of contiles 29d. Deta signed (Month, Dey, Year) Attending Mysician 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ATEL CX21 MONTROSS 31. Dete filed (Month, Day, Year) SEP 1 0 1998 32. Registrer's Signeture State Registrar



		State of	Maryland /	Department Certificate			nd Menta		ene	29	134
	1. Decedent's Name (First, Midd	fle, Last)						te of Death	1		3. Time of Death
Physician /Medical	Richan	d Eugene Zeig	ler				_	pt. 6.	1998	Year]	1:18 PM
Examiner	4e Facility Neme (If not institution	on, give street and num	ber)		4		n, or Location	of Death	4c. County	of Death	
	Homewood Retirem					Frede			Freder	ick	
Funeral Director	5. Social Security Number 179–05–7204	6. Sex 1 XI M 2 □ F	7. Age (In yrs. lest) 83	yrs. If Under Months	Days	If Under 24 Hours	Min. (Me	te of Birth onth, Dey,	Year) 1915	9. Birthplac Country Pa.	ce (Stete or Foreign r)
1	Usuel Residence of Decedent 10a, State 10b, Count	,	10c. City. To	own or Location						10d	I. Inside City Limits
f show	Md. Frede	rick		dletown							1X0 Yes 2 □ No
or 28s-f st be notified Director	10e. Street and Number			10f. Zip	Code			10	og. Citizen of	What Country	n
	15 Linden Blvd				2176	9		T	J.S.A.		
r ttems 23uniner must	11. Marital Status	12. Was Deced	dent Ever in U,S.	13. Was Deced	dent of H	ispanic Origi	n? (Specify Ye	es or No-	14. Rad	ce - American	
	1 Never Married 2 Mar	Armed Fore	2 No 1945-	1 Yes			Puerto Rican,	etc.)		ck, White, etc	0.
D 5	3₺ Widowed 4 □ Divorce	d Year or Da		TO Yes	ZIAJ NO	эреспу.			Specif	White	
went, the Medical. Be Completed		nt's Education est grade completed)	16	Sa. Decedent's Usue (Give kind of wor life. DO NOT us	ol Occupa	ation during most o	of working	1	6b. Kind of B	usiness/Indus	stry
A Ide	Elementary/Secondary (0-12)	Coilege (1-	4or 5+)		se retired	1)			Fodows	1 ~~-1+	
S H	11	(and)		estimator		10 Mathad	s Name (First,	Adiatala A		l gov't.	
ad off	17. Father's Name (First, Middle Charles (O. Zeigler					che R. S			пө)	
To To				Ob. Mailing Address	/Ctanat					State 7/a C	lada)
T la r	19a. informant's Name/Relation Mark C. Zeigler (9b. Mailing Address 2121 Wainwr					21.702	, 3tete, 21p C	000)
the S	20a. Method of Disposition		20b. Place	of Disposition (Nen	ne of		Det	7	20c. Locetion	- City or Towr	n. State
100	Burial A Cremation		ceme	ned Cemetery or o	ther pled	(e)	9/10				
Tall Carlo	4 Donation 5 Other (S		NEIGH	22. Name an		ee of Eacility		14.	fiddleto	wn, Ma.	
mportant: any injury ance.	21. Signature of Furieral Bervice	1/10 1					Funeral :	Home			
attanding physician and for use as the bunat-transit clar/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last	b	Due to (or as	a consequence of): a consequence of):							
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d for a	Part II. Other significant conditi	ione contribution to do	th but not require	n in the underlying	Allea air	en in Dest I	1.0	3h Did to	hacco use or	antribute to *	he cause of death
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nis certifica Il director, To Be (examiner?	Hospitel:	patient 2 ER/	Outpatient 3 DC	Oth	00:	sing Home 5			her (Snecity)	
eral c	27. Manner of Deeth	28a. Date of			8c. Injur		7		w injury occu	_	
F: Aft	1 Naturel 5 Pendi	ng (Month igation	, Dey rear)	Injury M		k≀ Yes 2 □ N	lo				
by th	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined 286. Place	of Injury - At home, g, etc. (Specify)	farm, street, fectory	y, office		28f. Lo	cation (Sti	reet and Num	ber or Aural I	Route Number,
To the Funetal Director: After Incompletely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifyi	ng Physician: To the b	est of my knowled				place, end du	e to the ce	euse(s) end m		
within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral di Medical Certification: To	one)	and mann					, Social ed at t				
To the common of	29b. Signature and fifte of certific	n 4.0	luis 1/2	> mis	D. Licens	e number	428	25	9d. Date sign	od (Month, De	ey, Year)
	30. Name and address of person	who completed cause	of death (Item 23	a) (Type, Print) 4	15+	L FI	eder	incl	5, m	02	170/
State	31. Date filed (Month, Day, Year	32. Re	gistrar's Signeture	1 4	1	al .					

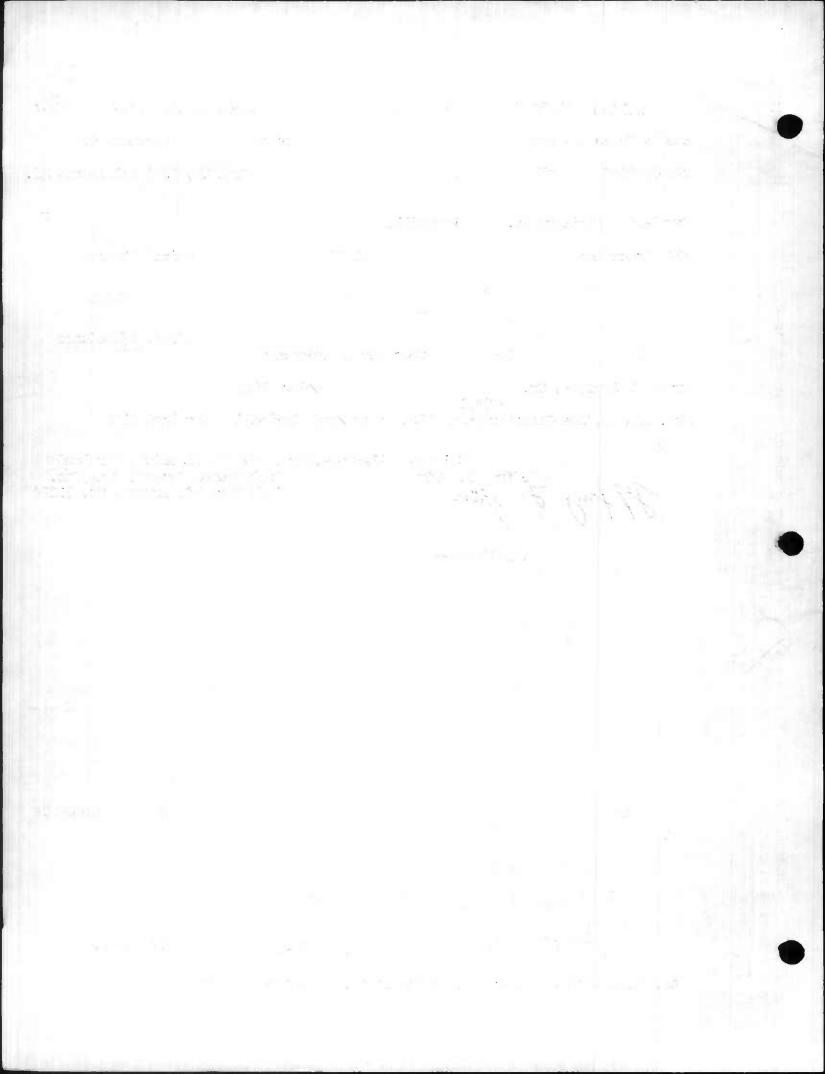


				State	of Ma	ryland		artmen rtificat			and M	lental Hyg	ieneg (3 2	9135
	Physicia * /Medic		1. Decedent's Name (First, Midd AVARA, ANGELII									2. Dete of Deel		98 ^{Yeer}	3. Time of Deeth 8:45am
)	Examin	er	4a Facility Name (If not Institutio ST. Elizabeth 's 5. Sociel Security Number	Home 6. Sex	7. Age	(In yrs. les	st birthday)	If Under		altim	ore	8. Dete of Birth	4c. Cour	ty of Deeth	
ŀ	Director		215-05-6122 Usuel Residence of Decedent	10 M 20 F	0	19	Yrs.					Feb 21,		PA	
	Ba-f ahow	ector	MD Baltim				Town or Lo	lle							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	N with th	al Dir	409 Lee Drive					10f. Zip		228			0g. Citizen o	Whet Cou	intry?
5-0020	urs a	by Funeral Director	11. Marital Status 1 □ Never Marriad 2 □ Mar 3 ☒ Widowed 4 □ Divorced	ried 1 Te	Forces? s 2 ⊠ No Give			Was Deced f Yes, spec 1 Yes	cify Cuba	ispenic Ori in, Mexican Specify:	gin? (Spo i, Puarto	ecify Yes or No- Rican, atc.)	14. R	ace - Amar ack, White ify: Whi	
21215-0	be filed within 72 ho ttal Hygiene. d other than "natur avant, the Medical	Be Completed	15. Deceder (Spacify only highs Elementery/Secondary (0-12)	1	d) (1-4or 5+		16e. Deced (Give life. I	kind of wo	el Occupe rk done d se retired	etlon during mos i)	t of work		16b. Kind of Own Ho		ndustry
Maryland	Men Men arke	To Be C	17. Fether's Neme (First, Middle, Carmello DiG								dali	ne Ge	Malden Sum rdina	ame)	
e j	Health a Form 27 Is other train		19e. Informant's Neme/Relations John Avara-Gran 20a. Mathod of Disposition 1 Buriel 2 Crametion	dson 3 Ramoval fro	m Stata	20b. Pla		OSEWC sition (Nar matory or o	od A	ve, (Cato	nsville, Date /18/98 E	MD 2 20c. Location	21228 n - City or 1	Fown, Stete
Baitin	permit. Pages Department of Important: If it any injury or o		4 Donetion 5 Other (S			St.	22	2. Name an	d Addras	ss of Facilit	rIW v	ZKE FUN	ERAL H	OMES,	INC.
)	Dur De	cai Examiner	23a. Pert1. Enter the disease, o shock, or heart teilure. List Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events		sev D	Due to (or e	es a consecutive c	quence of):			cardiac	or respiretory err	est,		Approximate Interval Between Onset and Deeth
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ecords	requi	Completed b										24e. Wes e perfor	en autopsy med?	8	Vere autopsy findings valiable prior to completion of ceuse of deeth?
VITAI H	sician: The law certificate has t lirector, page 2 s		25. Was cese referred to medice	4						26 Diago	of Doot	1 ☐ Y	es 2 No	1	☐ Yes 2☐ No
ō	y sign	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Deeth 1 Naturel 5 Pendir	Hospitel: 1 [28e. De (M gation	Inpatiente of Injury onth, Dey	Yeer) 2	R/Outpetier 28b. Time of Injury	M 2	8c. Injun Wor	er: 4 🖾 Nu	nrsing Ho	me 5 - Reside	ence 6 Co	urred	rel Route Number,
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l				usser	Mn	3	421 3		he	BL	him	nine	мп	L12	27
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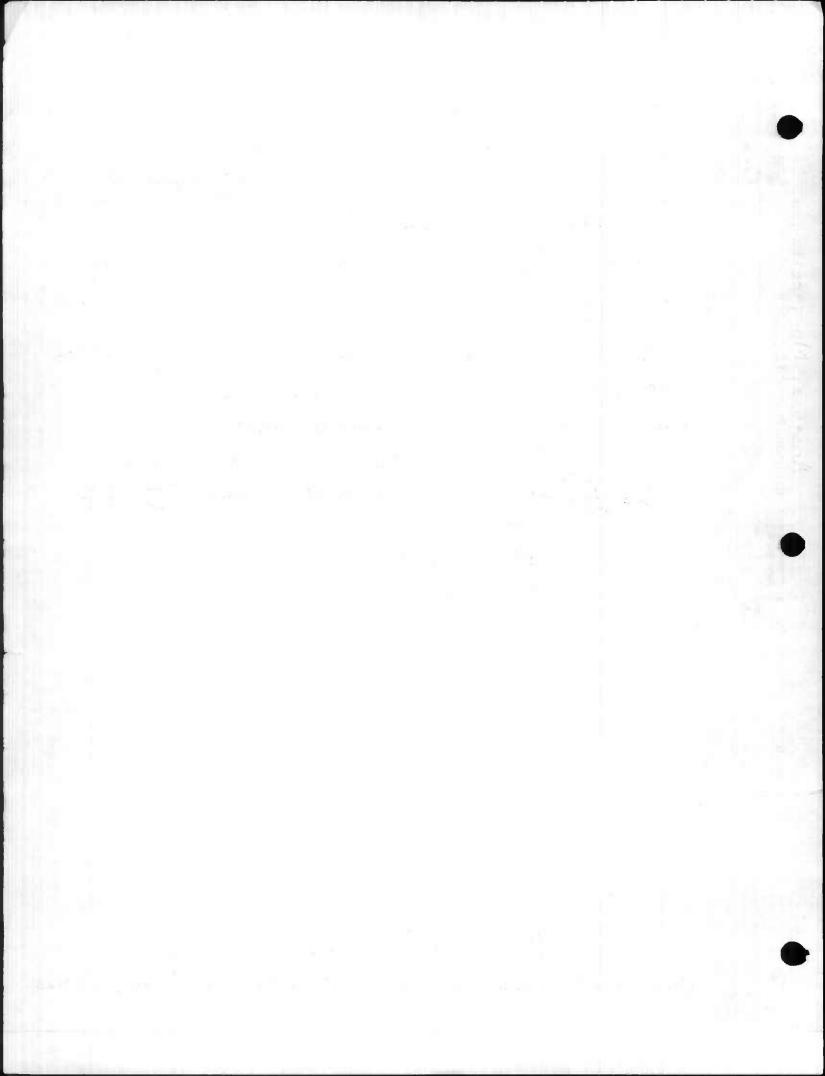


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	24	Decedent's Name (First, Middle, Le	est)		Certific	ate of	Death	2. Date of Dec	Reg. No.	3.1	ime of Death
Physicia /Medic	cal	RONALD MI 4e. Fecility Name (If not Institution, gir	CHAFL	ARME	TTA		4b. City, Town, or	September	Day 23	1800	648/A
Examin	er	Stella Maris Hosp					Timoniu		10.000	imore Co	
Funeral				(In yrs. last bi	irthday) If Ur	nder 1 Year	If Under 24 Hrs				
Director.		213-52-8307 Usuel Residence of Decedent	1□M 2□ F	49	Yrs. Mont	hs Deys	Hours Min.	8. Date of Birt (Month, Da June 2	0, 1949	9. Birthplace (Country) Baltimo	ore, M
natural, or items 23a or 28a-f show	10	10e. Stete 10b. County		10c. City, Tov	n or Location						side City Lim
8a-f	Director	Maryland Baltimo	re Co.	Park							☐Yes 2DX
0 8		10e. Street and Number				Zip Code			10g. Citizen of		
23	eral	8721 Roper Road	12. Was Decedent Ev	or in 11 C		21234	line and a Only in 2 (0			States	
al', or items 23a or 28a-f show Examinet must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:			s 212 No	dispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)		ce - American Ind ck, White, etc. by: White	nan,
"natural", adical Exp	ted	15. Decedent's E (Specify only highest gr	ducation	16a	. Decedent's L	Jsual Occup	pation during most of wo	4.6.0	16b. Kind of B	usiness/Industry	
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= 0 5	Be C	17. Fether's Name (First, Middle, Last						me (First, Middle,	Meiden Sumen	ne)	
	ToE	Frank V. Armetta,	Sr.				Helen K	uhn			
and lis m		19a. Informant's Name/Relationship					end Number or Ri)
= N F		Mrs. Lisa K. (nee	Jesse)Armet		21 Rop		ad Park	ville, M	-		
ant of t: If It y or o		20e. Method of Disposition 1	Removal from State	cemete	of Disposition (ory, cremetory (ev Vall)	or other ple	m.Gard.	Date 9/26/98		City or Town, Si	
Department of important: If any injury or once.		21. Signature of Funeral Service Licer					ss of Fecility Ruc		n Funer	al Home,	Inc.
caminer	ner	disease or condition resulting in deeth)	a. Gliobla		consequence	of):					
in and rial-trans	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	b	ue to (or as e	consequence	of):					
hanna de mar	/Medical	Cause (Disease or Injury thet initiated events resulting in deeth) Last	c	ue to (or as e	consequence o	of):					
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	/ Physician/M	Part II. Other significent conditions of	ontributing to death but	not resulting i	n the underlyin	ig cause giv	en in Part I.			ntribute to the c	
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ath. r: After th		27. Manner of Deeth 1 (2Netural 5 Pending investigatio			Time of Injury M	28c. Injur Wor 1 🗆	yet k? Yes 2 □ No	28d. Describe h	low injury occur	red	
within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At home, fa (Specify)	arm, street, fac	tory, office		28f. Location (S City or Tow	itreet end Numb n, State)	per or Rurel Rout	e Number,
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15) /and	= MD	ab //a		Du	13725		9/-	22/98	
1)		30. Name end address of person who DR. TARIO MAHMOO				RD	TIMONIUM	MD 210	03		
Stat	te	31. Date filed (Mant) Day, Xear 1998	32 Registrar				_ LLION LOIT	للک سند و			



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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) LL 30 September 4c. County of Death LAURA ALFORD 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) Age (In yrs. last birthday) 91 Yrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/18/1907 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 280 F Florida 10b. County 10c. City, Town or Location 10d Inside City Limits N/A Baltimore 1 ☑ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of Whet Country? 21216 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. Specify: Black

the Marylar 7 is marked other than "natural", or frems 23a or 28a-f shov traumatic event, the Maxical Exatranar must be incitified at Pages 1 and 2 should be 1 nent of Health and Mental I of Health and N Department of F Important: If Ite any injury or oth

68760

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

To

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31. Date filed (Month, Day, Yeer) SEP 2 2 1998

page 2 1

Division of Vital Records, P.O. after death Director: ö 24 hours e Funeral To the Y

GENSIS Elder Care 5. Social Security Number 220-14-1673 Usuel Residence of Decedent 10a. State MD Director 10e. Street and Number 2900 Roslyn Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes WNo Specify: by 3 ☐ Widowed 4 € Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) St. Joseph Hospital Elementary/Secondary (0-12) College (1-4or 5+) Practical Nurse 10th 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Be Carrie Pickman Castor Samuel Castor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Sylvia M. Johnson 9959 Guilford Road, Jessup, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 9 / 2 2 / 9 8 Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removal from State Baltimore, Maryland Voshell Memorial Gardens 4 ☐ Donation _5 ☐ Other (Specify) 22. Name and Address of Facility Willie E. Howell, Jr.
LEROY O. DYETT & SON FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the deem to not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Congestive heart failure Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequenca of): Physician/M Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. imbelance PV PV 24a. Was an autopsy Completed

23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 DeNo 8 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) Other. 458 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 DCCertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certified (Check only one)

29b. Signeture end title of certifier

29c. License number D-40521

29d. Date signed (Month, Day, Year) Sept 19,1998

Approximate Interval Between Onset and Deeth

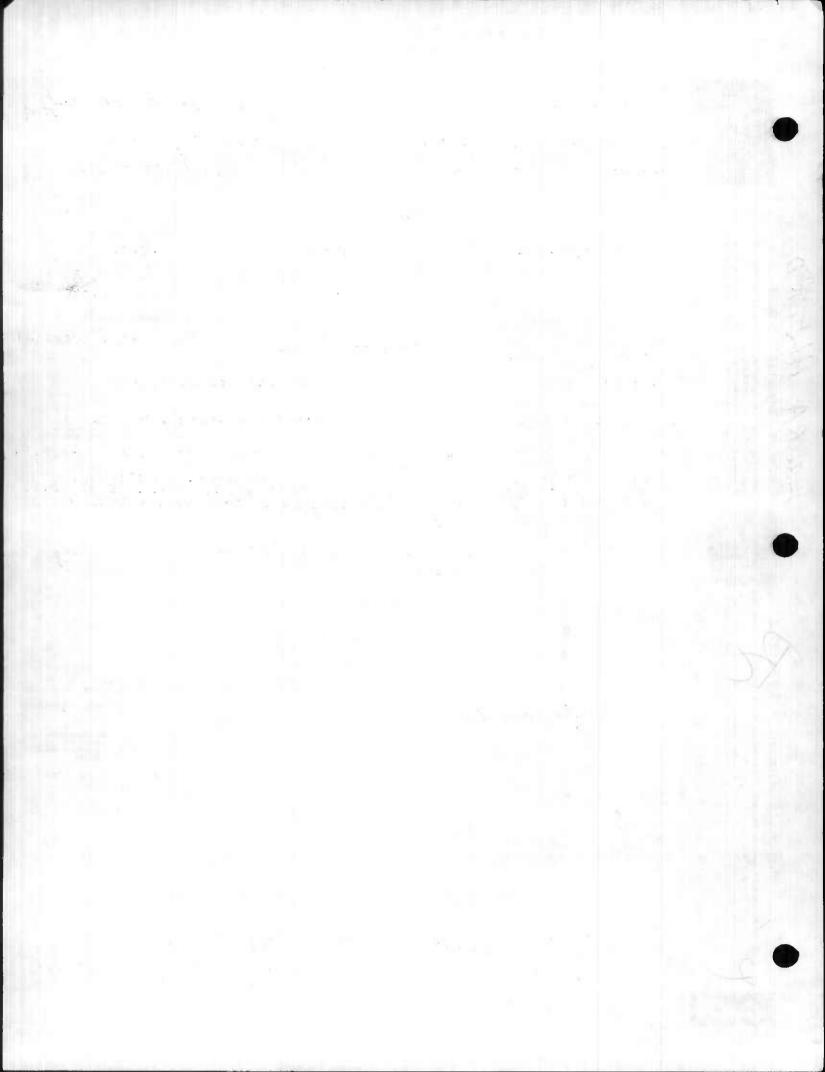
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR.OCHANE

> 32 Registrar's Signature mun

3350 Wilkens Saltimore, MD

Avenue Suite 302

Registrar



State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** SEPTEMBER 11,1998 7:45 A.M. /Medical Name (If not Institution, give st 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Saint Mary's Hospital Leonardtown Saint Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 24, 1907 5. Social Security Number 508-12-6175 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Cmaha Nebraska **Funeral** 10M NOF Months Deys 91 Yrs. Director Usuel Residence of Decedent the Manyland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or items 23a or 23a-f show traumatic event, the Medical Examiner must be notified at MD St. Mary's Lexington Park 1 ☐ Yes > No Director 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 45899 Kristi Lynn Court 20653-3301 United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 3 ☐ No Specify: Specify White by 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "neny Injury or other traumatic avant Elemantary/Secondary (0-12) Collega (1-4or 5+) N/A 12th Grade Home Maker Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Nicholas Larkovic Anna Tomec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Boswell / Son 45899 Kristi Lynn Court, Lexington Park, MD 20653 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Calvary Cemetery September 14,1998 Omaha, NE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Victor P. Doda, Jr. 22, Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Pert1. Enter the disease, or complications that caused the distribution, both on the enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Onsat and Death **Physician** /Medical Immediata Causa (Final Can Inversal and diseese or condition resulting in death) Examiner Sequantially list conditions, if any, laading to immadiate ceuse. Enter Underlying Causa (Disaese or Injury that initiated events resulting in death) Lest Dua to (or as a consequence of): Physician/Medicai Due to (or as e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy lindings evelleble prior to completion of cause of death? 24e. Was an autopsy performed? Completed certificate 1 ☐ Yes 2 ☑ No of Vital 25. Was cesa ralarrad to medicel Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 12 Yas 2 No ŧ Magnar of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Dascribe how injury occurred After Division Natural 2 Accident 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) after A 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, daath occurred at the time, dete and place, and due to the cause(s) and manner as stated.

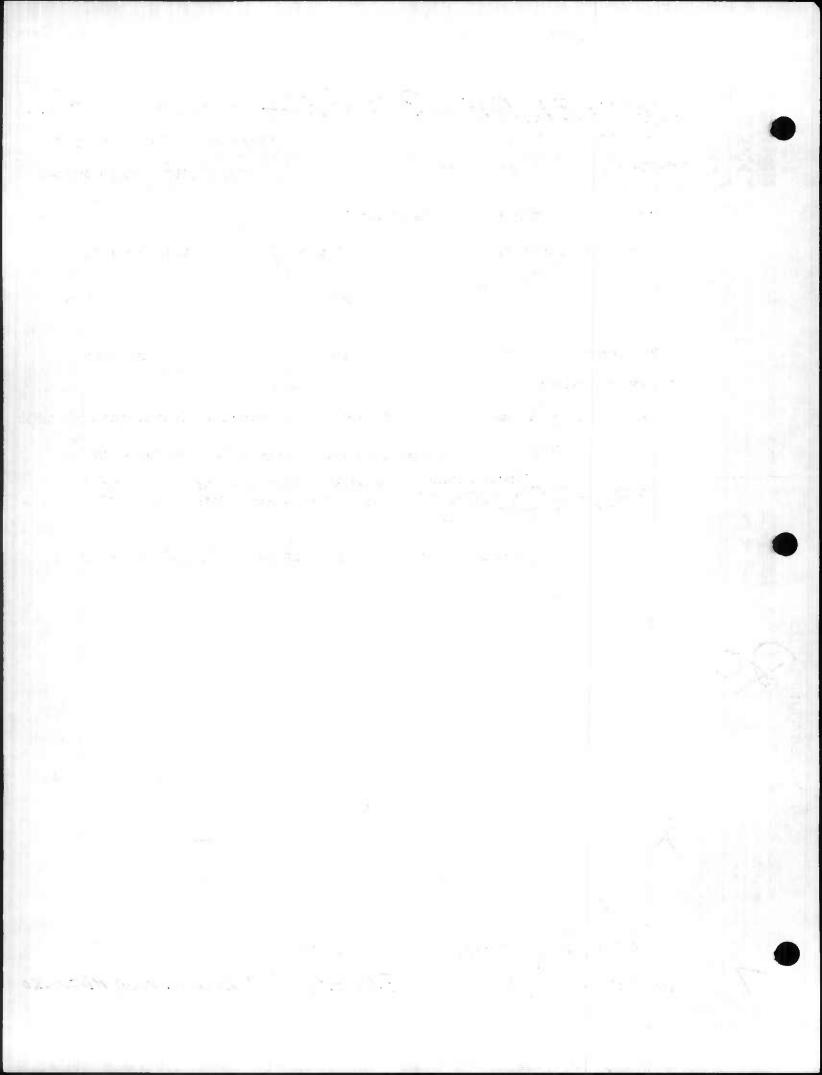
Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature end title of certifie 29d. Date signad (Month, Day, Year) 29c. License number 30. Name and address of person who complated cause of deeth (Item 23a) (Type, Print) DR. William P.O. BOX 527 LCONARDTOWN, HD 20650 Boyd 31. Date liled (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

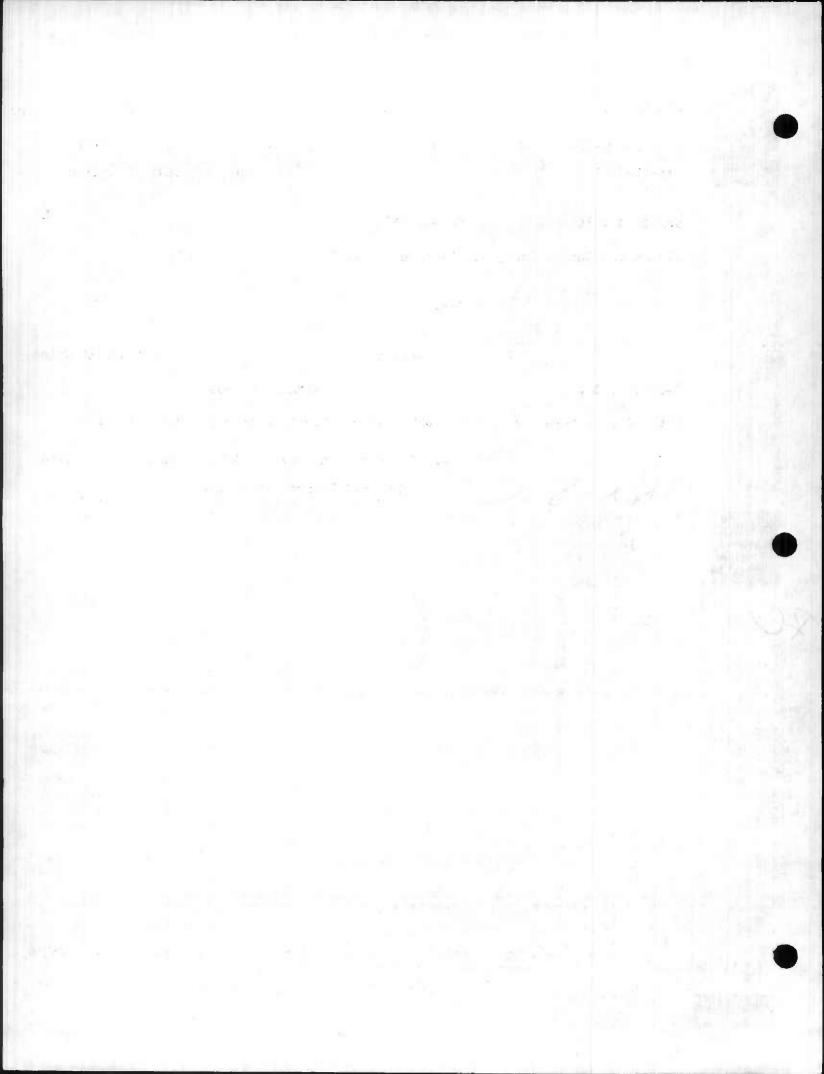
SEP 2 3 1998

CATHERINE LUCILLE



State of Maryland / Department of Health and Mental Hygiene

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Physicia		Charles B. Born						Seot		78 12:1
/Medic		4a. Facility Nama (If not Institution, giv	a straat and numbar)				4b. City, Town, or			
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uneral irector		5. Social Sacurity Number 6. S 215-05-0691	Sex 7. Ag	a (In yrs. las 80	t birthday) If	Undar 1 Yaar onths Days	If Undar 24 Hrs. Hours Min.		, Yaar) , 1918	9. Birthplaca (Stata or Country) Maryland
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x 28	irec	10e. Street and Number			1	Of, Zip Coda			10g. Citizan of WI	hat Country?
238	aiD	717 Maiden Choic	e Lane, St	. Char	rles	21228			USA	
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e marked o	To B	George G. Born					Katherin	e Bense	L	
marked imatic e		19e. Informent's Name/Reletionship (Type, Print)		19b. Mailing Ad	ddrass (Street	and Number or Ru	ıral Routa Numbe	r, City or Town, S	State, Zip Coda)
		Catherine M. Born	n / Daug	hter 8	820 Hol	lins S	treet, Ba	ltimore	Maryla	nd 21201
item 27 ie marke · other traumatic		20a. Method of Disposition		20b. Plac	of Disposition	n (Nama of		Data	20c. Location - C	City or Town, Stata
ortant: If It Injury or B.		1 ☐ Burlal 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Spacif			raine P			/24/98	Baltimo	re, Maryla
important: if its any injury or of once.		21. Signature of Funeral Service Licer	1500		Hub		uneral Ho			aryland 21
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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Vasi **Physician** September 21, 1998 1:20 a.m. FLORENCE BALDA ROSALIND /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2MF Months Days Hours Yrs. Director 223-34-4624 84 1914 Sept. 8, Iowa Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8901 B Waltham Woods Rd. 21234 USA Funeral should be filed within 72 hours after death on Mental Hygiene.
I merked other than "natural", or Items 23. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: altimore, Maryland 21215-0020 p 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home maker Own home traumatic event, 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be is marked o Kauth 10 Henry Joseph Anna Reuter 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m eny injury or other traum pnce. 8901 B Waltham Woods Rd. Baltimore, Md. 21234 Jacqueline Balda/daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 9/25/98 Baltimore, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Kidney Failure Examiner Due to (or as e consequence of): Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Physician/Medical thet initieted events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? **Dags 2** certificate has 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 28. Plece of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 2 Bills 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28c. Injury at Work? Certification: I or Attending P after death. Aftor 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral C 1X Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the 1 within 2 To the 9 complet de of pertifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature Mods 1-21-98. 15509 0 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

2300 DULANEY VALLEY RD.

32. Registrer's Signature

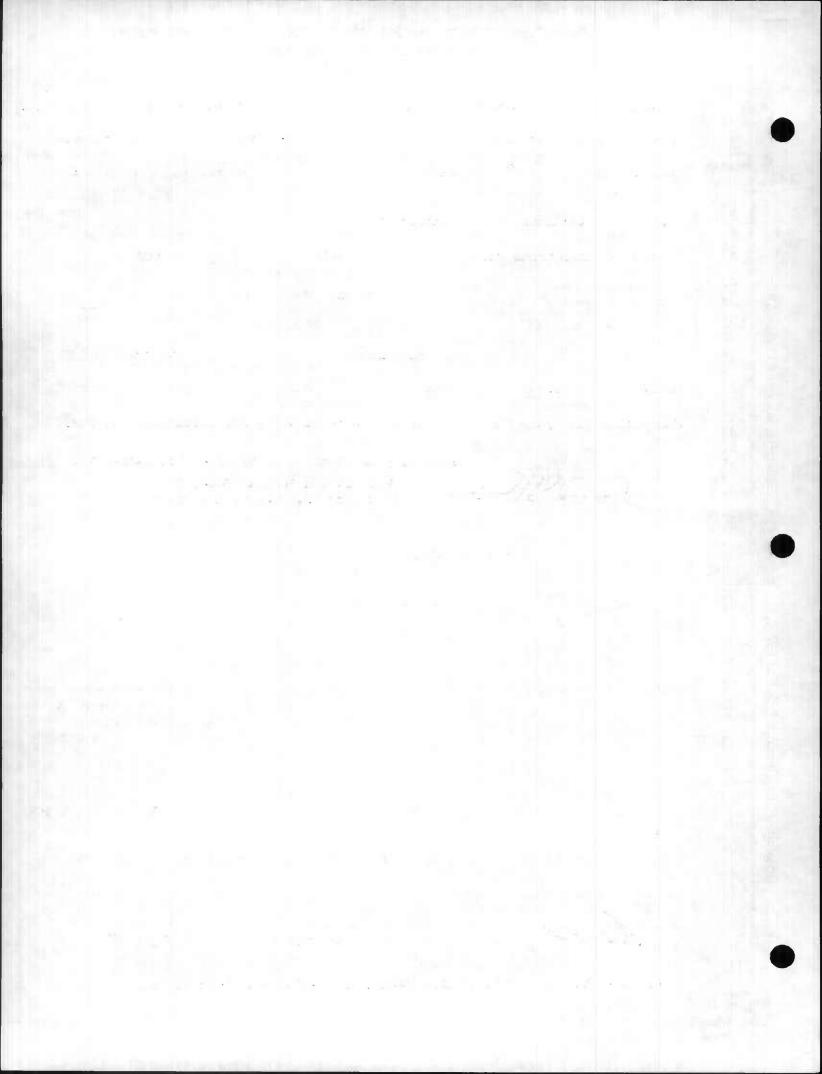
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Registrar

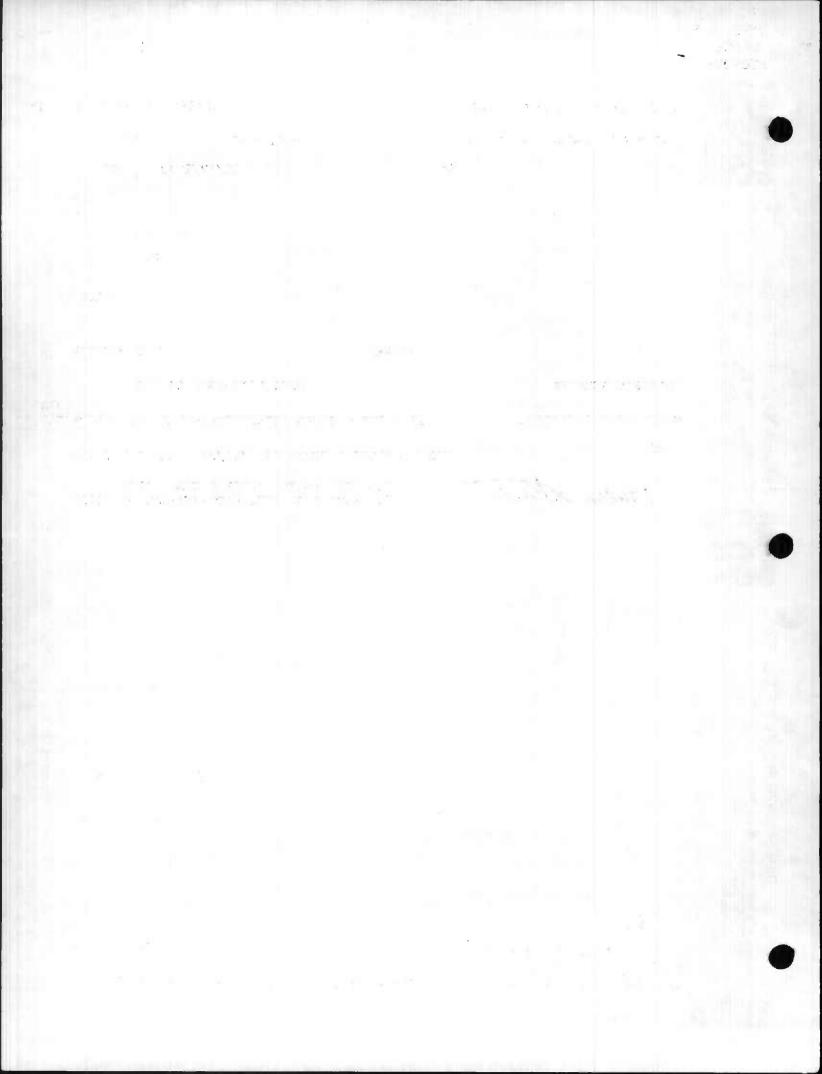
State

EDDIE NAKHUDA

31. Date filed (Month, Dey, Yeer) SEP 2 3 1998



State Registrar 31. Data filed (Month, Day, Year) SEP 2 3 1998 32. Pagistrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** emper 21 /Medical 4a. Fecility Neme (If not institution, give street and number Ab, City, Town, or Location of Death 4c. County of Death **Examiner** lana If Under 24 Hrs. Hours Min. 5. Social Security Number 9. Birthplace Country) If Under 1 Year In yrs. last birthday) (Stete or Foreign 1 M 2 F Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiens. Important: If term 27 is marked other than "naturel", or items 23a or 28af ehow any injury or other traumate event, the Medical Examiner main for notified at State 10b. County 10d. Inside City Limits 1 Yes 2 No Director timore 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? grove by Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

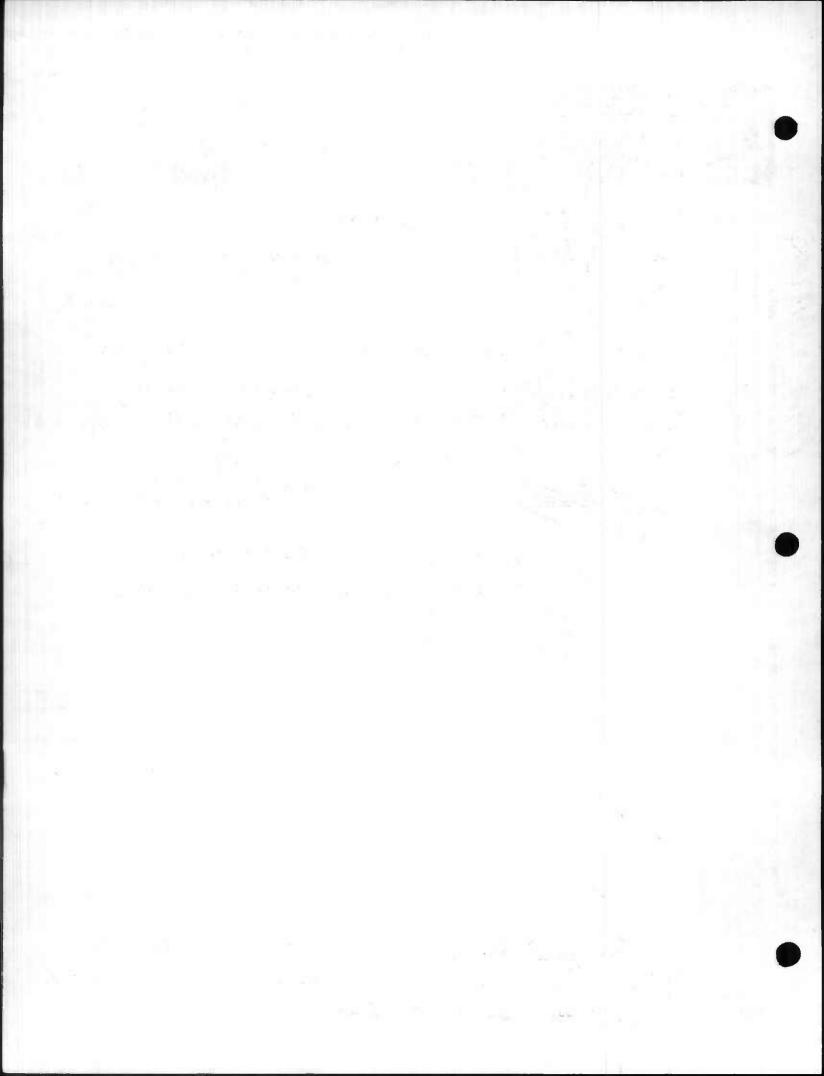
1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (154or 5+) Elementary/Secondary (0-12) House Keeper 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be luanita Wors le 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Grove St. 1505 Ripular altimore 20b. Place of Disposition (Name of cometery, cremetory or other place) Method of Disposition 1 Burial 2 Cremation 3 Removal from State Star Cem. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Fedlity albert 21. Signeture of Funeral Service Licensee 1+: more Part Lenier the disease, or completations that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest shock, or heart failure. List off one cause on each line. **Physician** /Medicai Immediate Cause (Final disease or condition resulting In death) Examiner burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown p 24b. Were autopsy findings svailable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 🗆 Yes 2 No 1 Yes 2 No certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 211 No Medical Certification: To 1 Yes 1 Dinpatient 2 ER/Outpatient 3 DOA funaral 27. Manner of Death 28b. Time of 28a. Dete of Injury (Month, Dev Year) 28c. Injury at Work? 28d. Describe how Injury occurred 5 ☐ Pending investigation 1 Naturel 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 4(mrs and address of person who completed cause of deeth (Item 23a) (Type, Print) Maryland General EnRIQUE GARCIA, M.D.

State Registrar 31. Date filed (Month, Day, Year)

2 3 1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month Yaar **Physician** 09 18 98 10:15am WILLIAM L. COLVIN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner FORT HOWARD BALTIMORE VA MHCS FORT HOWARD DIVISION 8. Data of Birth (Month, Day, Yea 6/25/32 5. Social Sacurity Number 6 Sex 7. Aga (In yrs. last birthday) If Under 1 Year | if Undar 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours 66 Yrs. 218-28-9850 Director VIRGINIA Usual Residence of Decedent the Maryland 10d. Inside City Limits worle 10a State 10b County 10c. City. Town or Location "naturel", or items 23s or 28s-f show 1 ☐ Yas 2 ☐ No Director MD. BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2604 PAGE DRIVE 21222 U.S.A. Ø death Funer Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedant Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black. White, etc. filed within 72 hours efter 1 □Yas 2 □ No
If Yes, Give
Year or Datas: 1951-55 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 Widowed 4 XDivorced Completed th end Mental Hygiene.
7 is marked other than "natur traumatic event, tre Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER ENGINEER 12 YRS. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ROBERT COLVIN ELIZABETH E BREEDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 2604 LYNBROOK RD. BALTIMORE, MD.21222 JEAN OTTO/SISTER
20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata Important: If it any injury or a once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State BALTIMORE WASHINGTON 4 Donation 5 Other (Specify) 9/19/98 LAUREL, MD. CREMATORY Address of Facility 21. Signature of Funeral Service Licens CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE. BALTIMORE, MD 21224 where the mode of dying, such as cardiac or respiratory errest, 23a. Pan1. Inter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final a CA LUNG WITH BRAIN METASTASIS 1 YEAR disaasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner an end Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. o 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, P. signed d be det þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peed certificate hes lirector, page 2 s The 1 Type 2 NO No 1 □ Yes 2 □ No or Attending Physician: director. 25. Was cesa referred to medical Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 Yes 2 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: After 1 XNatural 5 Pending 1 Yes 2 No investigation rector: by the t 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) Direc 4 - Homicide hin 24 hours after the Funeral Dire mpletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) To the To the To the Complet 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number lan: SEPTEMBER 18, 1998 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) AURORA C TAN MD, 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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VILLIAM L COLVIN

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Name (First, Middla, Last) Day Month Year **Physician** JEANNETTA C. COFFMAN SEPTEMBER 20, 1998 8:00AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 2010 MOUNT ROYAL TERRACE BALTIMORE If Under 1 Year Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days 1 M WY 88 Yrs. 300-01-8752 Director 05/02/1910 OH Usual Rasidance of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show a notified at 1 Yes 2 No Director N/A BALTIMORE ğ 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? r than "natural", or items 23s or the Medical Examiner must be r 2010 MOUNT ROYAL TERRACE 21217 U.S.A. Funeral 12. Was Decedent Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No if Yas, Giva Year or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian. Black, Whita, atc. 1 □ Navar Marriad 2 □ Married Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: WHITE à 3 X Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) filled within Hygiene. Elemantary/Secondary (0-12) Cotlega (1-4or 5+) 12 POSTMASTER US POST OFFICE 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) 88 n and Mental 1 should be CHESTER C. BROWN MINNIE PEARL ROSS 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n RON HAUGHN/SON 2010 MOUNT ROYAL TERRACE BALTIMORE, MD 21217 Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition Data 1 N Buriai 2 □ Cramation 3 □ Ramovai from Stata ò 4 Donation 5 Othar (Specify) McCOMB CEMETERY 9/23/98 McCOMB, OHIO 22. Nama and Addrass of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 complications that control the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, bist only one place on each line. Approximata Interval Batween Onsat and Daath **Physician** /Medical Imreediata Causa (Final diseasa or condition rasulting in daath) Examiner Examiner that the death certificate be executed Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaasa or Injury that initiated events end attending physician e for usa es the buriel-Box 68760. Physician/Medical that initiated evants rasulting in daath) Last Dua to (or as a consaquence of) 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. the 2 No 1 Yes 3 Probably 4 Unknown signed by 13heimers tun Records, þ requires 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed peen complation of cause of death? The law has 1 Yes No 1 Yas 2 No certificata Division of Vital Physician: Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Home Rasidanca 6 Othar (Specify) 1 Yas 2 No 0 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 200 27. Mannar of Death 28a. Data of injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: Atter 5 Panding invastigation Attending Naturat 1 Tas 2 No 2 Accidant after death 6 Could not be datarminad 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Spacify) 4 Homicida 8 within 24 hours To the Funeral 29s, Certifier 🔀 Cartifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. Medical

Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

(Itam 23a) (Type, Prin 5

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29c. License number

29d. Data signad (Month, Day, Year)

State

29b.

Registrar

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CROSS	ITEMS:	#23	PART	I,	27,	28A-F	PER	MEO	G764	10-7-98 wCertificate of Death	Reg. No.	30	6	
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Physicia	1	23 PART I,	ne (First, Midd	le, Lasi										2. Dete of D Month SEPTE	Reg. No Deeth		<u>19</u> 98	3. Time 3:25
/Medica Examine		4e Fecility Neme (um <i>ber)</i>					4b. (City, To	FCCI	ocation of Dee	eth 4	4c. County	of Deeth	·e
Funeral Director		5. Social Security I	59	6. Se	x 0 м 2□ F	7. Age	(In yrs. la.	st birthdey) Yrs.	If Unde Months	Dey:		Under Hours	24 Hrs. Min.	8. Date of B Month, D March	linth Dev Yes	1947	9. Birthp Coun West	lece (Stet
Marylend	TOL	Usual Residence of 10e. Stete Md •	10b. County Baltin				10c. City,	Town or Lo									1	0d. Inside
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be filed within 72 hours efter death with the Maryland tital hygiene. of other than "natural", or florms 23a or 23a-f show event, the Medical Examiner must be notified at	oy runeral	11. Meritel Stetus 1 ☑ Never Mar 3 □ Widowed			12. Wes Dec Armed F 1 Yes If Yes, G Yeer or	orces? 2 A No live			Ves Dece Yes, spe	city Cu	iben, i	enic Or Mexica Specify	n, Pueπo	ecify Yes or N Rican, etc.)	10-		k, White,	
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permit. Pag Department Important: f any injury o		21. Signature of F	4.5.	b	hand	1 caused t	the deeth.	I	296	rdt	Fu	inei	rall (Chapel Manche	este:	r, Md	. 21:	LO2 Approxin
Physician /Medicai Examiner		23a. Pent . Enter th disease, or complications that caused shock, or heer feilure. List only one cause on each lin						SUBDURAL HEMATOMA									Approxin Intervel E Onset en	
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or Attending Physician: The law requires that death. Director: After this certificate has been signe in by the funeral director, page 2 should be contification.	ibieren n													24a. We	es en eu dormed	itopsy ?	ev	ere autop: eilable pri mpletion d deeth?
hysician: The law his certificate has bil director, page 2 s	200	25. Wes case refe	rred to medica	ıl							2	6. Piec	e of Deet	h (Check only	1	2 No	1/2	Yes 2
Physician: rthis certific inal director.	2	examiner? 1 XYes 2				Inpatien		R/Outpetien		JA	Other:		ursing Ho	Home 5 X Residence 6 □Other (Specify)				
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after de Directo		3 ☐ Suicide 4 ☐ Homicide	6 🖪 Could detern	nined	28e. Plec build	a of Injur	ry - At hom (Specify)	e, farm, str	et, factor	y, office	0		17	28f. Location City or T			er or Rure	A Route N

ntribute to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy findings eveilable prior to completion of cause of deeth? Yes 2 No

City or Town, Stete imore, Md.

Approximete Intervel Between Onset end Deeth

3:25 PM.

10d. Inside City Limits 1 ☐ Yes 2 ☐ No

9. Birthplece (State or Foreign West Virginia

28f. Location (Street and Number or Rural Route Number, City or Town, State) UNKNOWN

1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner stated. 29a. Certifier (Check only

29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. SEPTEMBER 22, 1998

of deeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Dete filed (Month, Day, Year) 2 3 1998 32. Hegistrar's Signature

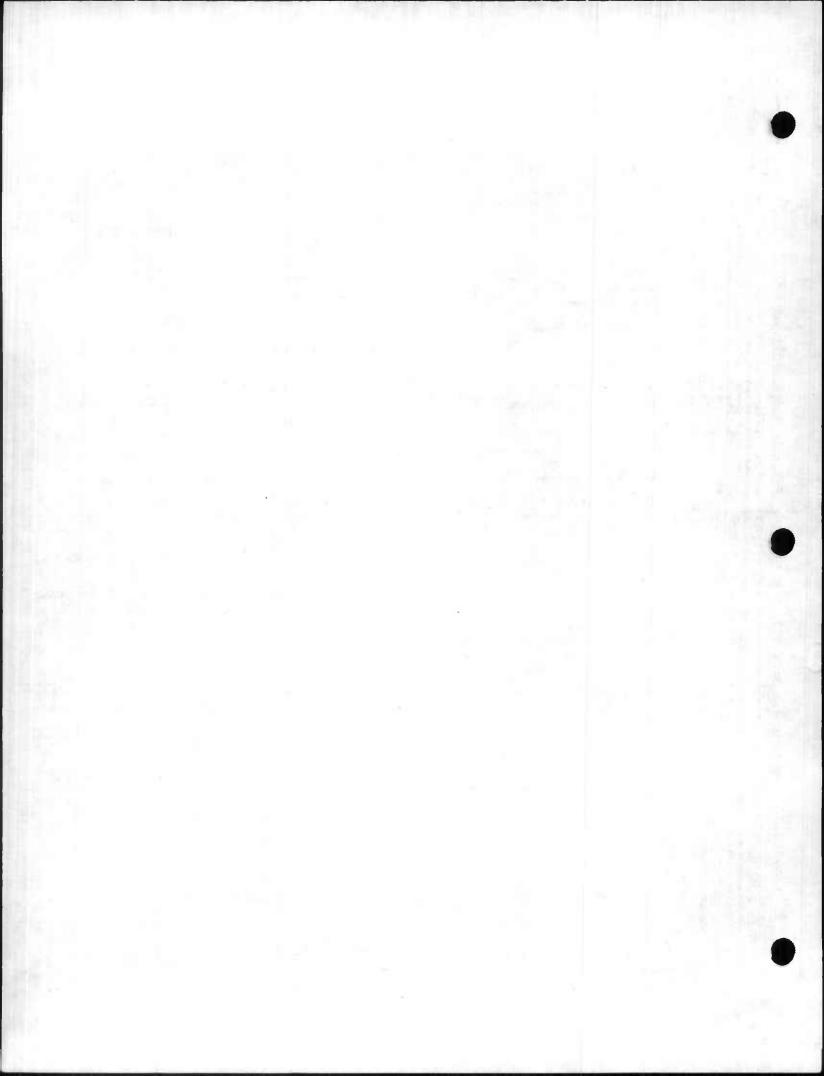
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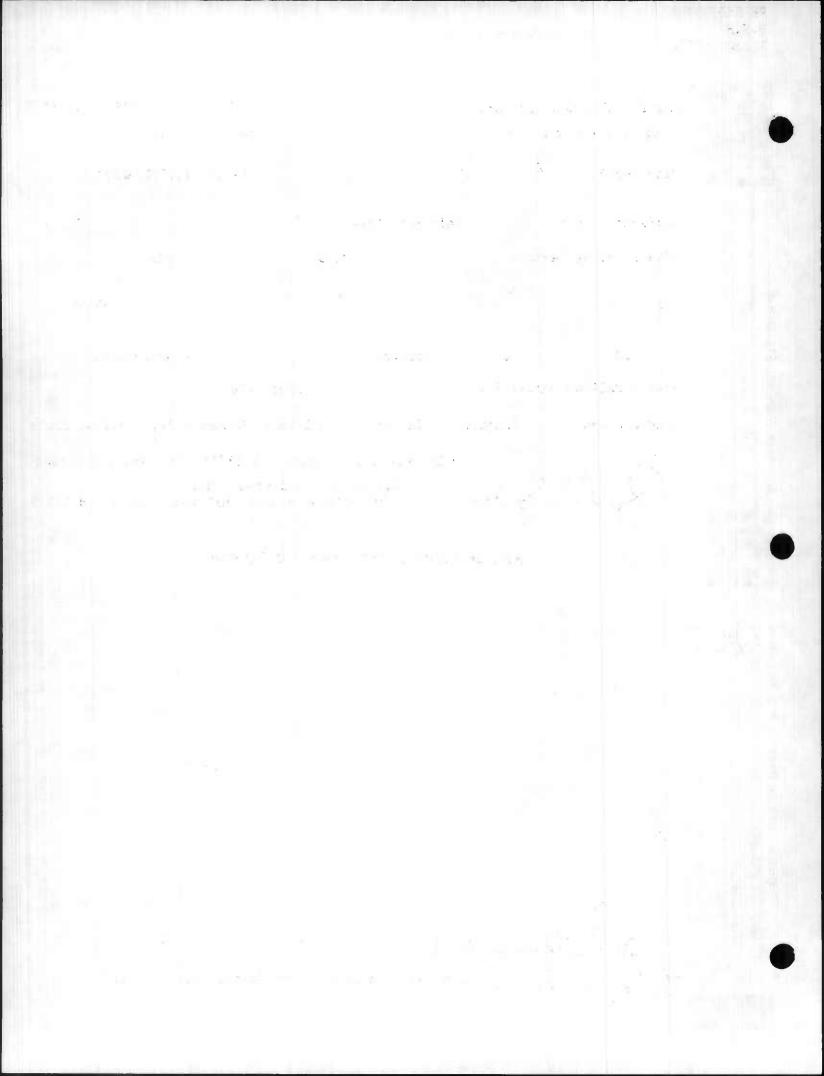
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			Certif	icate of	Death		Reg. No.	6.7	1 13 1
Dhusisis	1. Decedent's Name (First, Middle, Las	0				2. Date of D		Year	3. Time of Death
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Pu Maria	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location	on				10d.	Inside City Limits
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aber aber	MD N/2	1		Of. Zip Code			10g. Citizen of N	What Country	?
ith with the Marylar 23a or 28e-f ehow		INE AVE		2	1218		U.S.A		
020	11. Merital Status 1 Never Married 20 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Decedent of s, specify Cut Yes 2 No	Hispanic Origin? (S pan, Mexican, Puerl Specify:	specify Yes or N to Rican, etc.)	o- 14. Rac Blac Specify	e - American ck, White, etc.	
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1/) = 9520	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Other (Specify,	Removel from Stete	Plece of Disposition cometery, cremeted LTIMORE	ry or other pla		Date 9-11-9	20c. Location - BALTO		State
™ 88 € 5 8	21. Signature of Funeral Service Licens	in Holle			ess of Facility B:		UNERAL		213
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Physician /Medical Examiner	Immediate Cause (Finat disease or condition resulting in death)	. Cerebro	Va Va S		- Acci			2	2 days.
Box 68760, sath certificate be executed attending physician and for use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	or es a consequen		y artero	y disea vascu	se Perip lar Dise	heraj 2	.6 years.
W 2 2 2	Part II. Other significant conditions co	ntributing to death but not res	ulting in the under	hring cause o	iven in Part I	23h Did	I tobacco uma co	ntriburto to th	e cause of death?
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of Vita Physician: This certific al director,	examiner?	Hospital:	ER/Outpatient :	DOA O	hor		sidence 6 DOth	er (Specify)	- I was
10 5	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			how injury occur		
ion malin	1 Natural 5 Pending investigation	(monus, Day 1 bar)			Yes 2 No				
Divis dor Atta	27. Manner of Death 1	28e. Place of Injury - At h building, etc. (Special	ome, farm, street,	lectory, office		28f. Location City or To	(Street and Numb own, State)	er or Rural R	oute Number,
	29e. Certifier 1 Certifying Phy	sician: To the best of my kno mer: On the basis of examine and manner steted.	wledge, deeth occition and/or investi	curred et the togation, in my	ime, date and place opinion, death occu	and due to the urred at the time	e cause(s) and ma , date and place,	anner as state and due to the	e cause(s)
	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signe	d (Month, Day	y, Year)
	D'hara Man	1000		1.1-	12000	,	5 1	- 11	10.00
	30. Name and address of person who co	ompleted cause of death (Iter	1 11	1412	438941 on Memo	0	Septem	סנר ל	19 7 8
1	31. Date filed (Month, Dely, Year)	S. /VAS I/V	MD	Uni	on Memo	rial	Hospita	il f	saltono
State Registra	SED 7 9 MINO	Deve	4	1 .					



State of Maryland / Department of Health and Mental Hygiene 9 8 29 148

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	Examiner	48			give street and n AVENUE	ium <i>ber)</i>				41		m, or Loca IMORE	ation of Deeth	4c. County n/a	of Death	
	Funeral Director	L	Sociel Security N	040	6. Sex 1∭ M 2□ F	7. Age (In yr		rhday) Yrs.	If Under 1 \ Months D		If Under 2 Hours	Min.	B. Date of Birt (Month, De arch 2	h y, Year) 1,1920	9. Birthp Cour Mary	olece (Stete or Foreign htty) Land
	pur *		suel Residence of	10b. County		10c. (City, Town	or Loc	ation						1	Od. Inside City Limits
	f sho	5 ,	Maryland													1 N Yes 2 No
	the the	10	De. Street and Nu		•	Da.	ltimo	re	10f. Zip Co	ode				10g. Citizen of \	What Cour	ntry?
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020	Z1Z15-UUZU ed within 72 hours after death with the Maryland ed within 72 hours after death with the Maryland stylene. t, the Most as Ensured must be notified at Completed by Funeral Director	11	Maritel Status Never Marr Widowed	ied 2□ Merrie	12. Was De	3 2 □ No Give	U,S.			of His Cuber	spenic Orig n, Mexican,	In? (Speci Puerto Ri			ck, White,	ean Indian, etc.
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215	arytang Z1Z15: should be filed within 72 and Mental Hygiene. marked other than "ne martic event, the Mone To Be Complete		(Spec	cify only highest	t grede completed	(1-4or 5+)	-	(Give k	ind of work of O NOT use r	done di retired)	uring most	of working	rking			
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pu			7. Father's Name	(First, Middle, L	.ast)			18. Mother's Name (First, Middle, Meiden Surname)								
Maryland	nd Mental narked o umatic eve		Albert W	illiam	Dogge, J	r.					Edna	a McC	ain			
lan	and is ma		9a. Informent's Na	ame/Reletionsh	iip (Type, Print)		196.	Malling	Address (S	Street e	nd Numbe	r or Rural I	Route Numbe	er, City or Town,	Stete, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 ho permit. Pages 1 and 2 should be filed within 72 ho bepartment of Haatib and Mental Hygiens. Important: if Item 27 is marked other than "natur any injury or other traumatic event, to Medical once. To Be Completed		19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, 2 19c. Malling Address (Street end Number or Rural Route Number, City or Town, Stete													
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-	THE PERSON	2	3a. Pert1. Enter f	he diseese, or o	complications the	t caused the de	ath. Do r	not enfe	r the mode o	of dying	, such es	cardiac or	respiretory e	rrest,	aryra	Approximate Interval Between
	Physician /Medical Examiner	d	nmediete Ceuse isease or conditio esulting in deeth)	(Finel	e. Arte	erioscl Due to	erot		-	vas	cular	Dise	ease			
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Box 68	cartes ndirection usa		esulting in death)	Lest	d											
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Division of Vital	Attending Physic death. ector: Atter this by the funeral diffication: To	27	7. Manner of Deet 14. Naturel 2 Accident		28e. Det (Mc	e of Injury onth, Dey Year)	28b. T	lime of njury		Injury Work		28		how injury occur		,,,
Divisi	after dea Director d in by the		3 ☐ Sulcide 4 ☐ Homicide	6 Could n determin	ned 200. Ple	ce of Injury - At Iding, etc. (Spe		rm, stre	et, factory, o	ffice		28	of. Location (City or To	Street end Num wn, Stete)	ber or Run	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th complataly filled in by the funeral Medical Certification:	2	9a. Certifier (Check only one)		Physician: To the saminer: On the end me											
	To the within To the compi		9b. Signature and	Lity Certifier	tanen	_ M.	0				number M.E			29d. Dete signe SEPT .	20,	Dey, Year) 1998
	10+1	30). Neme end addr	ess of person w	who completed ca	use of deeth (It	em 23e) (Type, F	nn Str	reet	, Bal	Ltimo	re, Ma	ryland	21201	1
	State Registrar		1. Date filed (Mon	SEP 23		Registrar's Sig	neture	G.	Spor	rek	2					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #20b Per FH Film G763 9-23-98RC Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 30 PM Month DUNCAN **Physician** 8 sept /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner 8. Data of Birth Month, Day, If Under 1 Birthplaca (State or Foreign Country) 7. Age (In yrs. lest birthdey) 5. Sociel Security Number 6. Sex **Funeral** 2/3-20-809. Usual Rasidenca of Decedent Months Deys Hours Min 1□ M 2 F Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Mexical Examinar mant by notified at page. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Ore Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citlzen of Whet Country? 25 do Funeral d 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14 Rece -American Indian 11. Maritel Status Bleck, White, etc. Yes 2 No f Yes, Give 1 □ Never Married 2 □ Married 1□ Yes 2,00 No Specify: þ 3⊠ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be 10 (Son 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stafe, Zip Code) 19a. Informant's Name/Relationship (Type, Print, Tone 1,00 20b. Plece of Disposition (Neme of FOREST cemetery, cremetery or other place) Data 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 30 4 □ Donation 5 □ Other (Specify) 21 Squature of Funeral Service Licenses 22. Name end Address of Facility 23. Art. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, hock, or haart failure. List only one cause on each line. 10. Approximata Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) oscleratic heart disease Physician/Medical Examiner Saquantially list conditions, if eny, leading to immediata cause. Entar Underlying Causa (Diseesa or Injury that initiated events resulting in deeth) Lest ani 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yss 2 70 3 Probably 4 Unknown

Physician /Medical Examiner

the Maryland

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

page 2 has

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completely

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certificate

this funeral

After

death.

after death Director:

Attending Physician:

6 Hospital within 24 hours

by 24b. Were sutopsy findings available prior to 24a. Wes en eutopsy performed? Completed completion of cause of daath? 20 No 25. Was casa raferred to medical examinar? 26. Place of Deeth (Check only one) Be Hospital: Othar: 4☐ Nursing Homa 5☐ Rasidanca 8 ☐ Other (Specify) 10 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Deett 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Natural 2 Accident 5 Pending 1 Yes 2 No Investigetion 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be detarmined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ HomicIde

29a. Cartifian (Check only one)

29b. Signeture and title of certifier

Certifying Physician: To the best of my knowladga, daath occurred at the time, date end placa, and due to the cause(s) end mannar es stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, daath occurred et the time, date end placa, and dua to the cause(s) end manner steted.

29c. License number

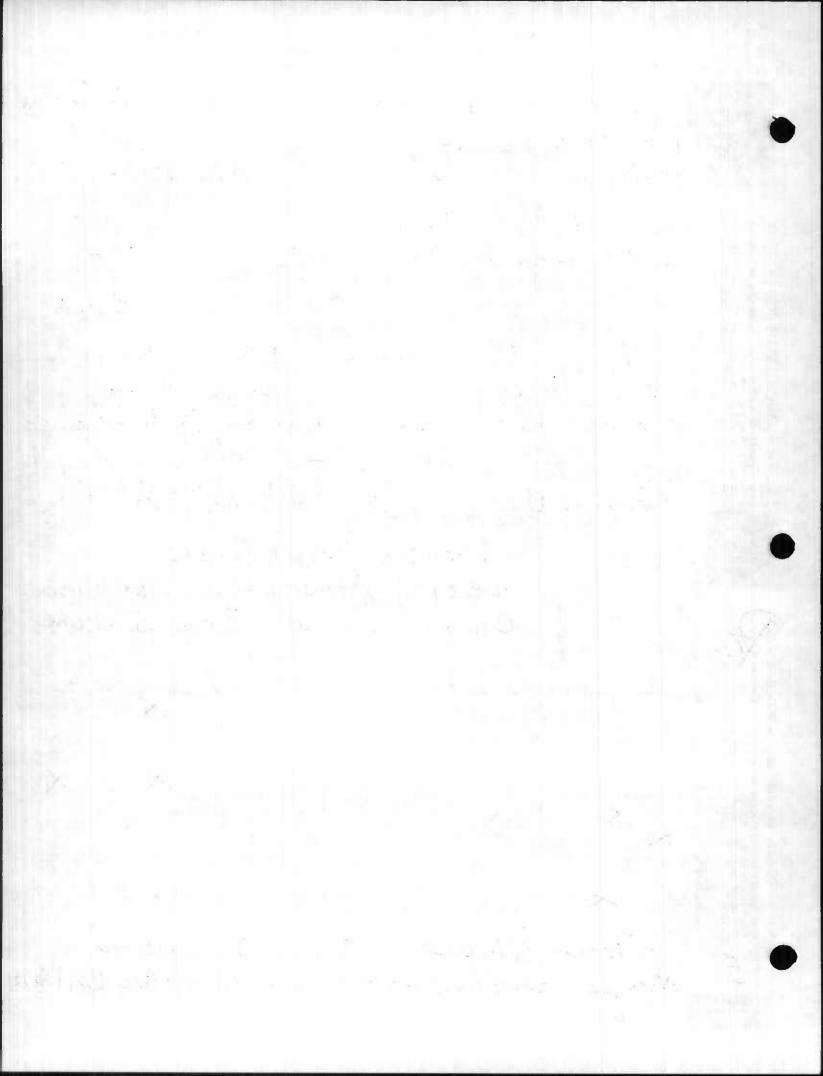
29d. Dete signed (Month, Dey, Year)

30. Name and address of person who complated causa of daath (Item 23a) (Type, Print)

Gebre mariam, M 100

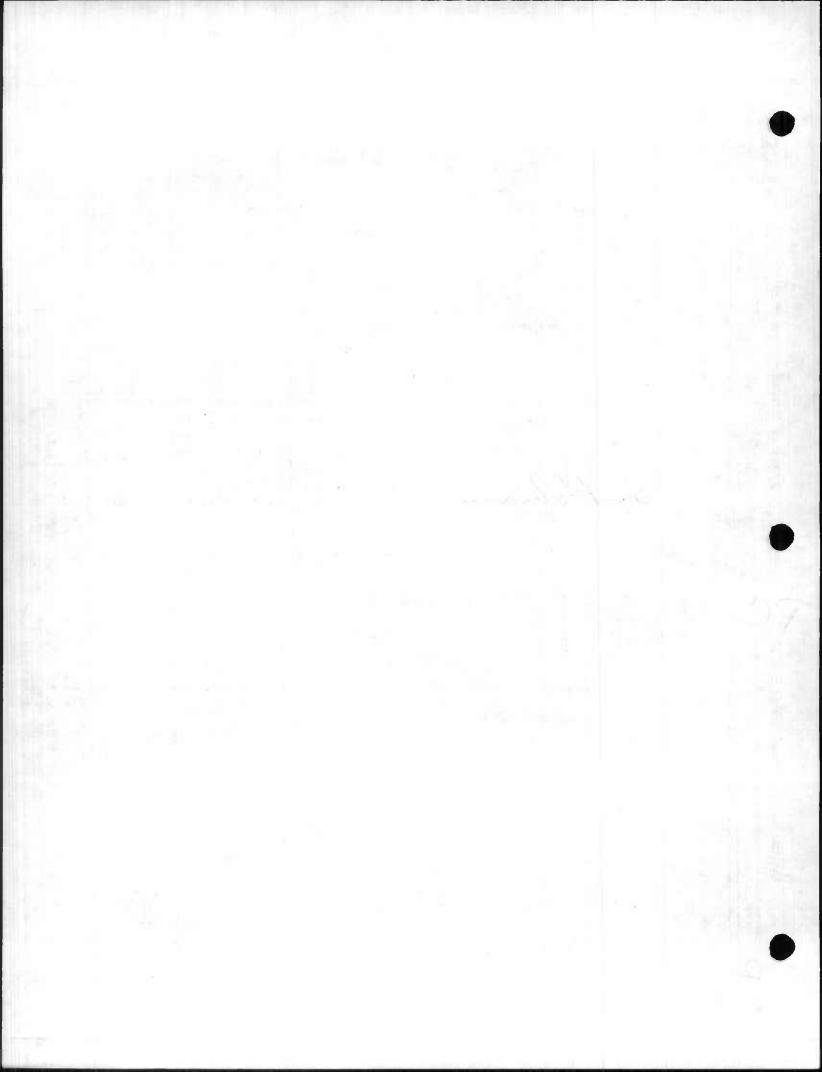
31. Date filed (Menth, Dey, Year) State SEP 2 3 1998 32 Registrar's Signeture

Registrar



State of Maryland / Department of Health and Mental Hygiene

	A Decident Many (First Middle)	41						Reg. No.		2 Ti 1 D 1
Physician	Decedent's Name (First, Middle, La Melanie	Elaine		Dan	iels		2. Dete of De Month	Day	Year 1000	3. Time of Death
/Medical				Dan	itera	4h City Town or	Septemi Location of Death			4:03 PM
Examiner	4a Facility Name (If not institution, gh 3712 Brenbrook Di				1	Randalls			altim	ore
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Funeral Director		1□ M 3€ F 2			ns Days					ce (State or Foreign y) sylvania
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uth with the Maryla 23e or 28e-1 show ust be notified at ral Director		r.	5	10f. 2	Zip Code	21133	TAI	10g. Citizen of V Unite		
020 ura after des afr, or Items Examiner m	3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 【▼No If Yes, Giva Yeer or Detes:	ı U,S.		cedent of pecify Cut	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	- 14. Race Bied Specify	e - Amarica k, White, et	
od within 72 ho od within 72 ho og within 72 ho og	15. Decedent's E	ducation	16a. E	Decedent's U	sual Occu	pation	16b. Kind of Business			ustry
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e se	20a. Method of Disposition		. Place of I	Disposition (A	Vame of or other pla	ece)	Date	20c. Location -	City or Tow	m, Stata
Page minim	1 ☐ Burial 2 🂢 Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			ount C			22/98	Baltim	ore,	MD
Baltimore semit. Pages 1: Separtment of Hs moortant. If Item ny injury or oth India.	21. Signature of Funeral Service bigar	(180)				ess of Facility				
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Physician	shock, or heert feilure. List only	one cause on each line.								Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760 tal or Attending Physician: The law requires that the deeth certificate be encured as after death. **All Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the purification. Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Lest Part II. Other significant conditions of axaminer? 1 Yes 2 No 27. Manner of Death 1 Neturel 5 Pending Investigation of Could not be determined. Per Check only 2 Medical Exer	Due to C	o (or es a co	patient 3 me of jury Mm, street, fect death occurre for investigati	DOA OI 28c. Inju. WC 1 Clory, office ed at the trion, in my 29c. Licen	26. Place of Dother: 26. Place of Dother: 1 Nursing 1 Yes 2 No 2 No 2 No 3 No 3 No 4 No 5 No 6 No	23b. Did 1 24a. Wes performed by the seath (Check only of the seath (Check only of the seath (City or Total)). Location (City or Total)	tobacco use con Yes 2 No an eutopsy rmed? Yes 2 No one) dence 8 Oth- how injury occurs street and Numb wn, State)	24b. War avai com of de 1 l	the cause of death? ably 4 Unknown re eutopsy findings lable prior to pletion of cause eeth? Yas 2 No Route Number, ited. the cause(s)
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IVISION Of VITAL RECORDS, P.O. BOX 68760 **Attending Physician: The law requires that the deeth certificate be excepted for death. Irector: After this certificate has been signed by the attending physician and noty the tuneral director, page 2 should be detached for use as the sunfactuant riffication: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Lest Part II. Other significant conditions of axaminer? 1 Yes 2 No 27. Manner of Death 1 Neturel 5 Pending Investigation of Could not be determined 29a. Certifier Check only 2 Medical Examiner? 29b. Signature and title of certifiar	Due to C	constant of the constant of th	patient 3 me of jury Mm, street, fect	DOA OI BOOK BOOK DOA OI BOOK BO	26. Place of Dother: 26. Place of Dother: 1 Nursing 1 Yes 2 No 2 No 2 No 3 No 3 No 4 No 5 No 6 No	23b. Did 1 24a. Wes performed at the time,	tobacco use cor Yes 2 No an eutopsy rmed? Yes 2 No one) dence 8 Oth- how injury occurs Street and Numb wn, State) cause(s) and me date end place, 29d. Date signed	24b. War avai com of do 1	the cause of death? ably 4 Unknown re eutopsy findings lable prior to pletion of cause eeth? Yas 2 No Route Number, ited. the cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day **Physician** ANNIS ELLEN MARLEY DOSH September 18, 190 tion of Death 4c. County of Death 1998 5:45 PM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MANOR CARE, RUXTON TOWSON If Under 24 Hrs. BALTIMORE COUNTY 5. Social Security Number 7 Age (In vrs. lest hirthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Min 1□M 20 F Months Hours Yrs Director 220-14-9525 94 Sept 15, 1904 Maryland Usual Rasidance of Decedan Maryland 10a Stata 10b Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Director Maryland Baltimore County Towson the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7001 North Charles Street 21204 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 72 hours after 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Phyliens important; if tem 27 is marked other the any filery or other traumatic event, the 1 page. 2 yrs Homemaker Own Residence 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William George Marley 0 Sarah Elizabeth Groom 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Catherinne R. Soares 20b. Place of Disposition (Name of cemetary, crematory or other place)

20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Prospect Hill Cemetery 9/22/98 Towson, Maryland 21. Signature, of Funeral Sarvices Uconsed 22. Nama and Address of Facility Muten Mitchell-Wiedefeld Home Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 ter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence of) edical Due to (or as a consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 | Yes 2 | No 3 | Probably 4 | Unknown þ 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was casa raferred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Tyes 2 No #Ide 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter Attending 1 Matural 5 Panding Investigation 1 Yes 2 No 2 Accident Director 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida after 8 To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Leading the Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29e. Cartifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of conflier 29c. License number of death (Item 23a) (Type, Print) 30. Name and addrass of au son who complet Ayman F. Akkad. 7600 Osler Drive #203, Towson, Maryland 21204

DHMH 16 Rev 6/95

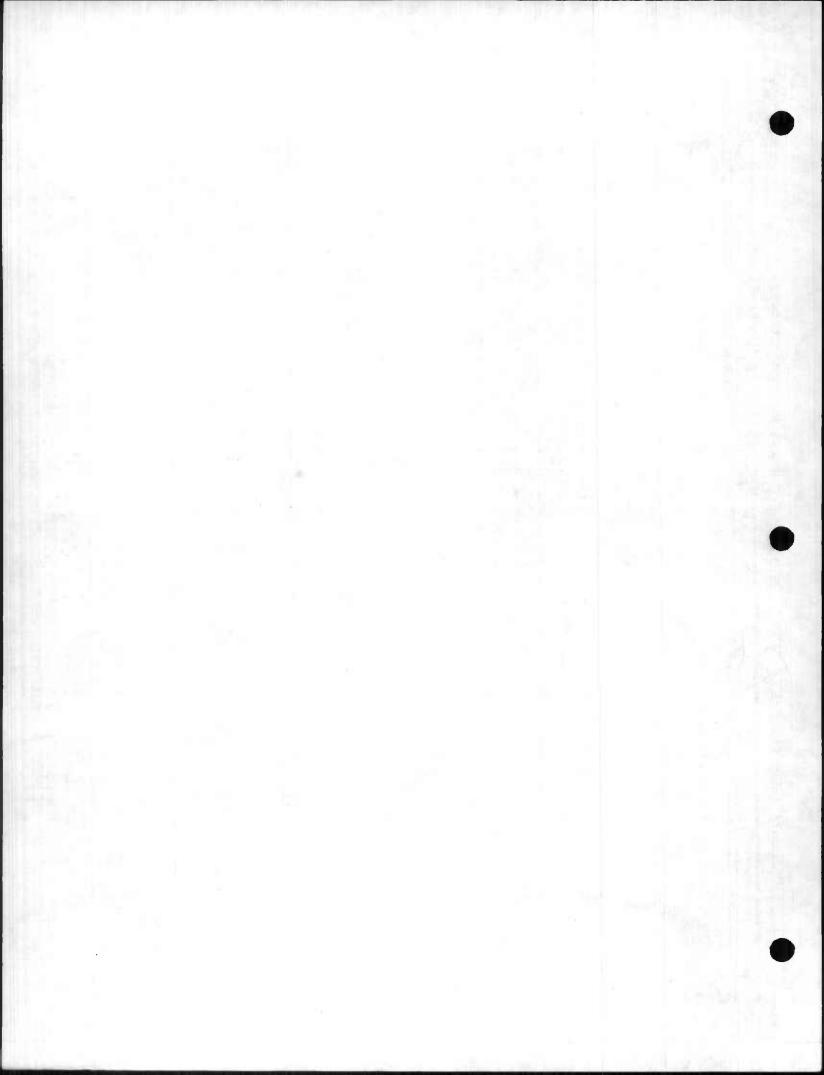
State

Registrar

31. Data filed (Month, Day, Year)

SEP 2 3 1998

32. Registrer's Signetura



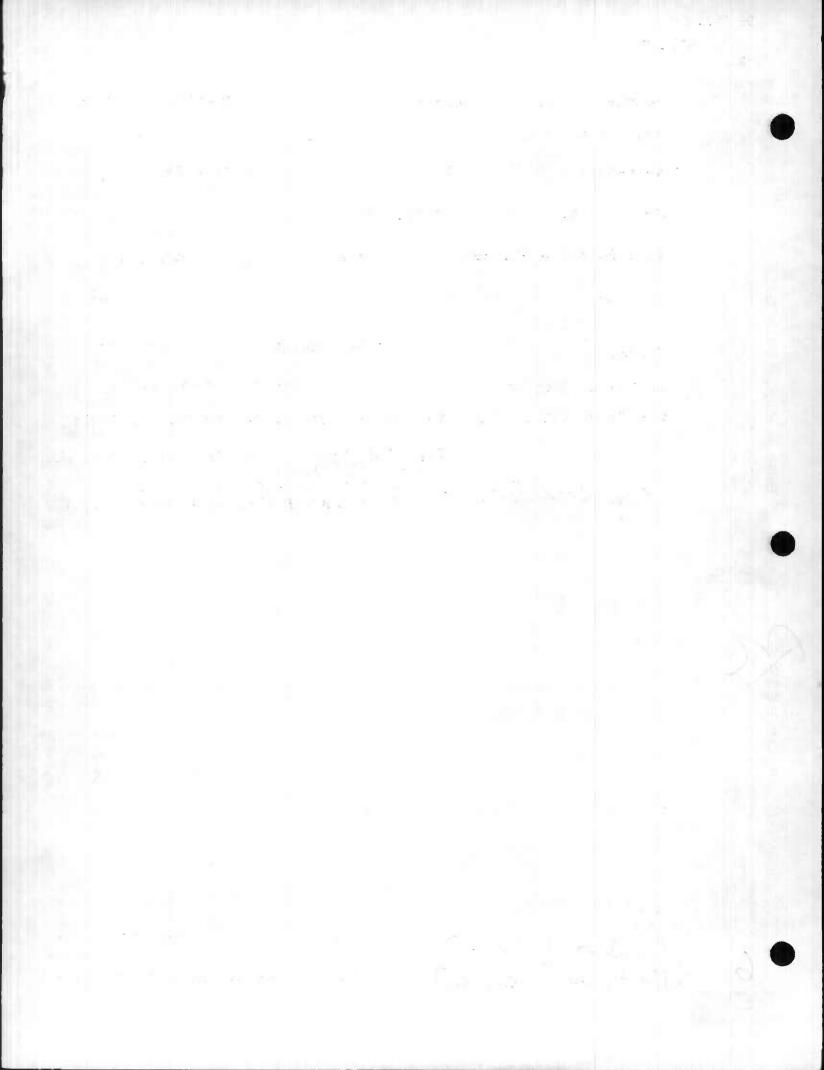
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ROGER	ENGLISH	State of Maryland / Department of Health and Mental		0010
ASO I	TEMS: #23 PART	I, II, 27 PER MEO G764 10-1-98 WRCertificate of Death	Reg. No.	2915

Physici /Medic	an	: #23 PART I, II, 2 1. Decedent's Name (First, Middle ROGERS			ENGL				20017		2. Date of D Month SEPT	eath EMBER 2	Year	Time of Death
Examin		4a Facility Name (If not institution BAYVIEW HOS	, give stre PITA	L					BALT	IMORI		N/A	of Death	
Funeral Director		5. Social Security Number 214-50-5444 Usual Residence of Decedent	6. Sex	1 2□ F	7. Age (In yrs) Yrs.		Days		Min.	8. Date of B (Month, D	irth Pay, Year) 11949	9. Birthplace (Country)	State or Foreign
Marylend a-f show	ctor	10a. State 10b. County MD . N/	A			ity, Town or Lo								side City Limits Yes 2□ No
eth with the Ma s 23a or 28a-f	ral Director	10e. Street and Number 1405 ANGELS					21	ip Coda	•			10g. Citizan of	Α	
Hemman Hemman	by Funeral	11. Marital Status 1 Never Marriad 2 Marri 3 Widowed 4 Divorced		Armed Ford 1 Yas If Yes, Give Yaar or Da	2 No	J,S. 13.	Was Dece If Yes, spe			gin? (Spe , Puerto	ecify Yas or N Ricen, atc.)		Race - Amarican Indian, Biack, White, etc.	
vithin 72 ho within 72 ho ene. then "netur	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)			4or 5+)	life.	DO NOT	ork doni use retir	ed) during most		ing		usiness/Industry	
be filed with the light with the light with the dotter the svent, the	Be	7 YRS. 17. Father's Neme (First, Middle,				F'A	CTOF	KY V		r's Name		e, Melden Sumer		
y, Maryland 21215-0020 and 2 should be filed within 72 hours of alth and Mentel Hygiene. 127 is marked other than "natural", or er traumatic avent, the Medical Exam	70	LESTER B. E 19a. Informent's Name/Relationsi CHRISTINA E	ip (Type	, Print)	AUGHT				at and Number	er or Rurs	l Route Num	DCKENBE: ber, City or Town, DRE, MD	State, Zip Code	•
Baltimore, permit. Pages 1 er Department of Hea Important: If item 2 any Injury or other		20a. Method of Disposition 1 □ Mourial 2 □ Cremation 4 □ Donation 5 □ Other (S)	3 □Rem		20b.	Plece of Disponentery, cre	osition (Ne matory or ANGE	ome of other pl	aca)	Q	Date		- City or Town, S	State
Physician /Medicale Examiner but coint and Examiner as the border/enterest	Medical Examiner	23a. Part 1. Enter the disease, or shock, or heart tailure. List Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underfying Cause (Disease or Injury that initiated events resulting in death) Last	e b c	tions that ca	SEIZURE Due to (DISORDE or as a conse	R quence of):):	ring, such as	cardiac	rraspiratory	arrest,	Appi	24 Coximate val Between et and Death
P.O. Both or hat the dayth or day the attended to use	Physician/	Part II. Other significant condition	ns contrit	buting to dea	ath but not re	sulting in the u	underlying	cause g	jiven in Part i			d tobacco use co		
cords,	by	ASTHMA; CHRON	IC AL	COHOLIS	SM						24a. Wa	s an autopsy formad?	24b. Were at	utopsy findings e prior to ion ot cause
al Re	Completed									,	V	Yes 2□No	X Yes	
Vital sician: T conflicat director, pu	o Be	25. Wes case referred to medical examiner? 1XXVes 2□ No	Hos	pital:	patient 2	ER/Outpatie	nt 3ŽŽ D	OA O	ther:		me 5□ Be	one) sidenca 6 □Oti	ner (Specify)	
Division of the Attending Physiather death. Director: After this dirt by the funeral dirt by	ation: T	27. Manner of Death 1 Netural 5 Pendin 2 Accident Investig	ation		f Injury n, Dey Yeer)	28b. Time o		28c. Inj W				how Injury occu		
DIVISION THE CONTROL OF THE CONTROL	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify)								ber or Rural Rou	ta Number,			
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledical		☐ Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred and manner stated.								e, date and place,	and dua to the	cause(s)	
To the within 2 To the comple	2	290. Signature and title of certifier	Lo	A 250									d (Month, Day, Year) ER 21, 1998	
6		30. Name and address of person	US COMP	pleted cause	NY	m 23a) (Type.		Per	n Str	eet,	Baltir	nore, Ma	ryland :	21201
Sta Registr	te ar	31. Dete filed (Month, Day, Year)	1998	32. Re	gistrar's Sign	ature &	de	sou	Kal					

G. Sparks

State Registrar



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31. Date filed (Month, Day, Year) SEP 2 3 1998 32. Registrar's Signature G. Sports

State Registrar

Marine Property As Kenen I on the And the second section of the second sections But I for all additions are assessment of a

State of Maryland / Department of Health and Mental Hygiene Item: 10c per F.H. G-763 9/23/98 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month **Physician** Frederick James Sept. 6:30am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 2669 Park Heights Avenue Baltimore 6. Sex 1 → 2 → F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs. Director 75 243-22-1423 19 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 □ No Director 28a-f MD 2669 NA Park Heights Ave 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2669 Park Heights Ave

1. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? 21215 Funeral U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. hours after 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2 Merried b Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 ital Hygiene. ad other than event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Welder NA Md. Dry Dock 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If Nem 27 is marked oth any Injury or other traumetic even 8 Allie Harvey 2 James W. Frederick 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiny Frederick-Wife 2669 Park Height Ave, altimore, Baltimore Md 21215 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery9/22/98 Baltimore, Md 21. Signature of Fundral Service Licensee 22. Name end Address of Fecility Baltimore, Maryland 21215 WM.C.March F.H. 4300 Wabash Avenue 23a. Part 1. Enter the disease, or complications that usused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on lach line. Approximete Interval Between Onset end Death **Physician** ASTHMA /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 45BES10515 Completed by HYPENTENSION 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? carlificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital After this certifical funeral director, 25. Was case referred to medical examiner? 8 26. Placa of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Afteridence 6 Other (Specify) Certification: To 1 X Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural after deeth.
Director: Aft 1 TYes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hooptal or withing 4 hours aft To the Funeral Dicompiesaly filled in 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner steted. 29d. Date signed (Month, Dey, Year) 29c. License number 031076 and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR, BALD, MR 21237

DHMH 16 Rev 6/95

State

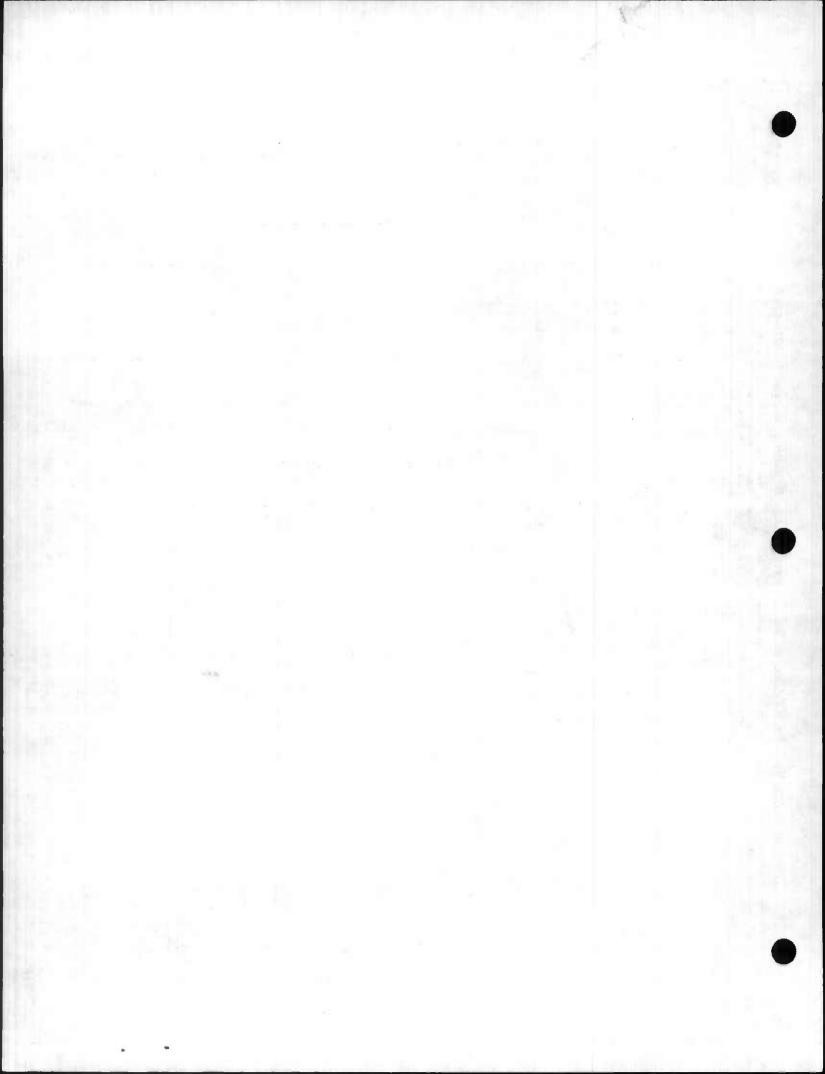
Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature



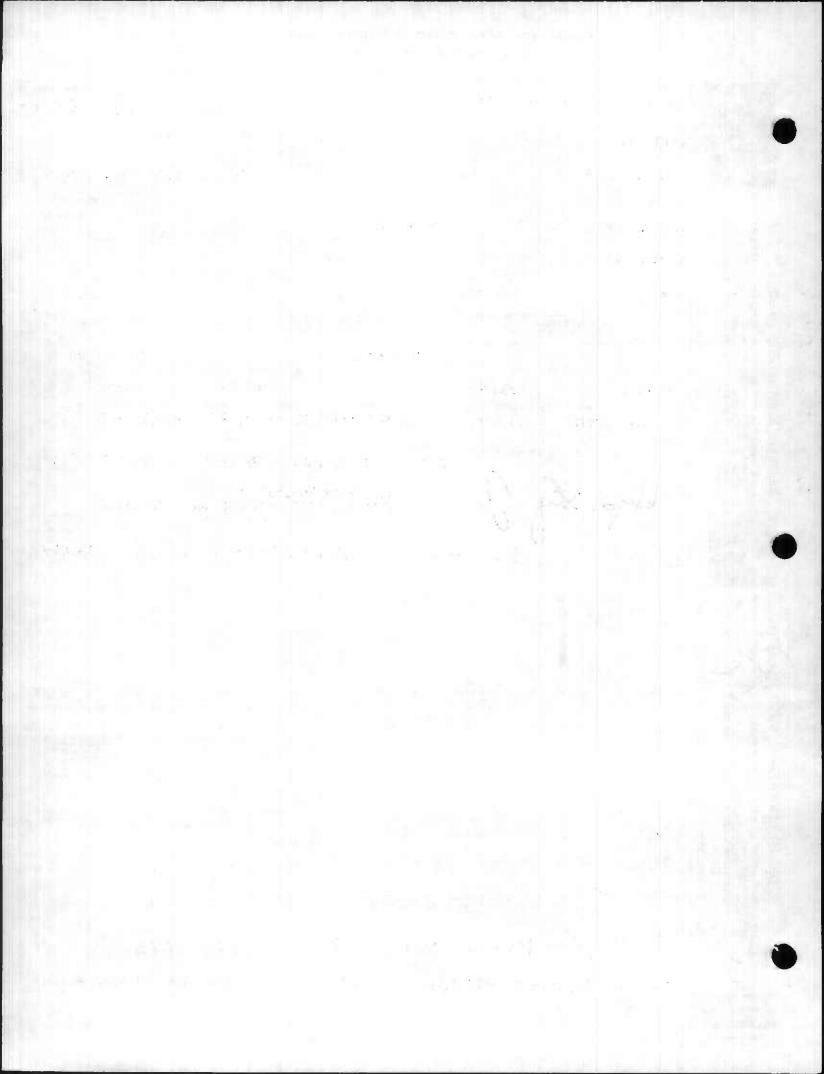
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Neme (First, Middle, Last) Month FISHER **Physician** LOISTTA JEAN 3.30 PM 2014 1998 SEPTEMBER · /Medical 4a Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** ANNIE ARUNDEL NORTH ARUNDEL HOSPITAL GLIEN BURNIE 8. Date of Birth (Month, Day, Year) If Undar 24 Hrs. If Under 1 Year Birthplace (Stete or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🖾 F Hours 214-76-3329 Director July 27 1930 West Virginia 68 Usuel Residence of Decedent 10b. County 10a, State 10c. City. Town or Location 10d. Insida City Limits than "natural", or lients 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☒ No Directo Maryland Anne Arundel Pasadena et and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 21122 USA 7765 Freetown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 □ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled never worked 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) d 2 should be fi th and Mental H 7 is marked off Be Priscilla McGee Fisher 2 Harrison 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5606 Patrick Henry Dr. Baltimore, MD 21225 rtant: If item 27 in njury or other tra Betty Irvine sister Pages 1 a 20b. Place of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 9/21/98 Baltimore Maryland 22. Name end Address of Fecility 21. Signature of Funeral Service Ligensee Stallings Funeral Home P.A.
3111 Mountain Road Pasadena,
23a. Perl1. Enter the disease, or complections that it used the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or hearly ellure. List only one ceuse by further. MD 21122 Approximete Intervel Between Onsat and Deeth **Physician** ENLEPHALOPATHY Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical HYPOXIC 4-DAY(Examiner Due to (or es e consequence of) Examine Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events Due to (or es e consequence of) pug 68760 edical thet initiated events resulting in deeth) Lest Due to (or es e consequence of): Physici Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? P.0. à 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ģ Division of Vital Records, 24b. Ware eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy periormad? Completed Tags Ser 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1 Yas 2 No Hospital: 1 ☑Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 # 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury et Work? Certification: ther 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. 2 Accident or Attend sher dead 6 Could not be 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) 2 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartif-MEDICAL DOCTOR D0052277 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ATTIOGIST ARLINDE HOSPITAL MARYLAND FRANCIS NORTH KWASHIE 32. Registrer's Signature

State Registrar

Jean

LOETTA



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 10:04 am 21, 1998 Cathleen Bell Finley Sept. /Medical 4s. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Sykesville Fairhaven Carroll If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) **Funeral** Months Deys Hours Min 1 ☐ M 2 🖫 F Yrs 9, Director 060-07-5853 95 1903 New York Usuei Residenca of Deceden with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flams 23a or 28a-f show traumetic event, the Medical Examiner must be notified at Sykesville MD Carroll 1 Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 U.S.A. Funeral death 12. Wes Decedent Ever In U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White by 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuei Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiere. Important: If Item 27 is marked other than "rany injury or other traumetic event, the Med Eiementery/Secondery (0-12) Coilege (1-4or 5+) Store Manager Retail Sales 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Frank Austin Bell Mertie Signor 19e. Informent's Neme/Relationship (Type, Print) 19b. Meliing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 N Court Street Westminster, MD 21157 Mr. Ronald Comfort, Attorney 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriei 2 Cremetion 3 ☐ Removei from Stete 9/23/98 Hampstead, MD Carroll Cremation Serv. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Fecility
HAIGHT FUNERAL HOME & CHAPEL (Box 195) DICE. Sykesville, MD 21784 (410)-795-1400 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, euch as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervsi Between Onset end Death **Physician** /Medical Immediate Csuse (Fine) diseese or condition resulting in deeth) minutes Examiner Due to (or es s consequence of) Examiner Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the causs of death? Division of Vital Records, P.O. 4 signed by 1 Yes 2 No 3 Probably 4 Unknown denentia þ 24b. Were sutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed Deen vilous adesoma 188 page 2 certificate 1 Yes 2 No Be 25. Wes case referred to medical examiner? 26, Pjace of Deeth (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 2 Nursing Home 5 Residence 6 Other (Specify) # funeral 27. Menner of Deeth

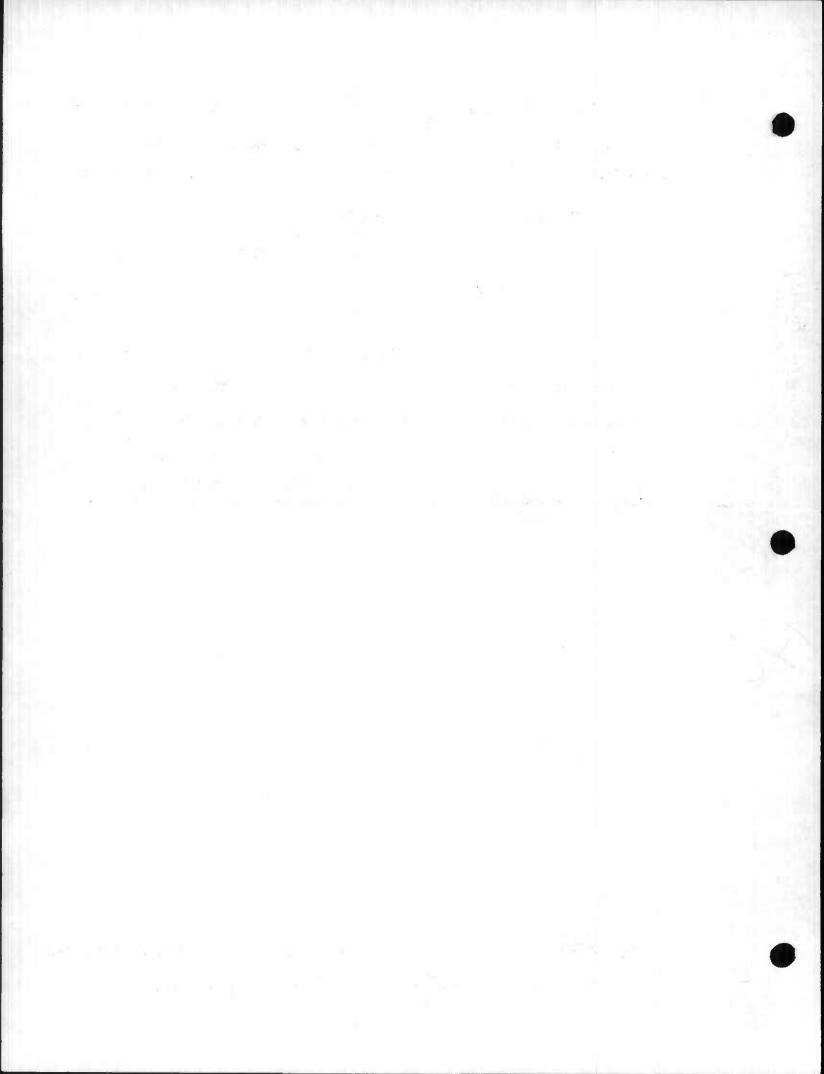
1 Neturel

2 Accident 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: if or Attending P after death. I Director: After After 5 Pending investigation 1 Yes 2 No 8 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) à 4 Homicide Hospital 24 hours a 24 hours Funeral Certifying Physicisn: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. Medicai 29e. Certifier (Check only one) To the To To the P 29b. Signeture end title of certified 29d. Dete signed (Month, Dey, Year) 29c. License number September 21, 1998 30. Name and eddress of person who completed cause of deeth (item 23a) (Type, Print) Eldesburg ND 21784 William lan 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture SEP 2 3 1998 Registrar

DHMH 16 Rsv 6/95

athleen Finley



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1442 DArrett DAR teven 2 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth olen B If Under 24 Hrs. 7. Age (In yrs. Mist birthdey) Glev Trunde urnie If Under 1 Year 5. Social Security Number 6 Sex Birthplaca (Stete or Foreign Country) Months Days Hours 1 7 M 2□ F 266-98-8802 Yrs. Sept 28 1955 New Jersey Usual Residence of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 √yes 2 No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21225 5328 Wasena Avenue USA 12. Was Decadent Ever In U.S. Armed Forces? 1 & Yes 2 □ No 1975 If Yes, Give Year or Dates: — 1978 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Never Married 2 ☐ Married 1 ☐ Yes XX No White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Grade 12 College (1-4or 5+) Truck Driver Recycling Company 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Elsie Winifred Yonker William Edgar Garrett 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William Garrett father 1417 Clearglades Dr. Wesley Chapel, Florida 33543 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Sep 25, 1 ☐ Buriel 2 XX remetion 3 ☐ Removal from Stete Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 1998 Catonsville, Md. 21. Signature of Funerel Service Licansee 22. Name and Address of Fecility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) UNKNOWN Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2000 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 NO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Yes 2□ No

Physician /Medical Examiner

The law requires thet the death certificate be executed

Box 68760.

P.0.

Records,

Vital Physician:

of

Division or Attending **Physician**

/Medical

Examiner

10a State

Md.

Director

Funeral

by

Completed

Be

Funeral

Director

"natural", or items 23s or 28s-f show

traumatic event, the Medical

then

Hygiene.

Peges 1 end 2 should be in nent of Health and Mental I

Health a

or other 1

Department of Important: If any injury or

deeth with the Marylend

filed within 72 hours after

Baltimore, Maryland 21215-0020

the 8 for use ate has been signed by the e page 2 should be detached to in by

certificate

this

To the Hospital within 24 hours a To the Funeral D

Examiner Physician/Medical þ Completed Be

Certification: To 27. Menner of Death

Medical

State Registrar

4 Homicide 29a. Certifier

1 Natural

2 Accident

3 Sulcide

6 Could not be

5 Pending Investigation

98 Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) tome

28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

1 Tes 2 12 No 28d. Describe how injury occurred OOK

norica Ct.

heroil 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3A/timore

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as steted.

Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier eput

29c. License number

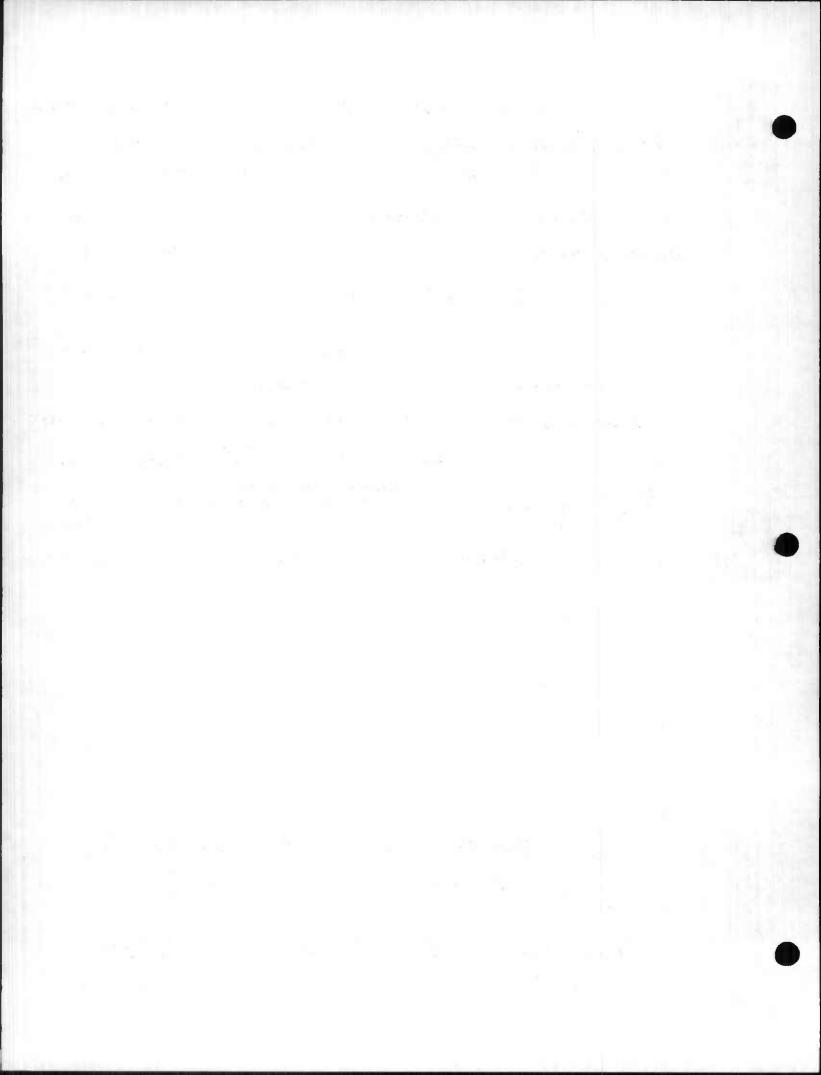
29d. Date signed (Month, Day, Year)

use of death (Item 23a) (Type, Print) , m.D JONES

31. Date filed (Month, Dey, Year) SEP 2 3 1998

32 Registrar's Signature

DHMH 16 Ray 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month Dev **Physician** SEPTEMBER 20 1998 2:27 pm JOE L. GRAHAM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER if Under 1 Year Months Devs If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number Sex 1M M 2□ F 8. Dete of Birth (Month, Dey, Year) **Funeral** Min Deys Hours 77 260-10-6074 Director 04/15/1921 GEORGIA Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland nent of Health end Mental Hygiena. Intent of Health end Mental Hygiena. Intent 21 fer marked other than "naturel", or items 23a or 28a-f show mir. If item 23a or 28a-f show my or other traumatic event, in a Medical Examine, man be notified at my or other traumatic event, in a Medical Examine, man be notified at 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2KXNo Director WHITE HALL BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17925 BACON ROAD 21163 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 △ Yes 2 ☐ No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien 11. Maritai Status Biack, Whife, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) PRODUCTION PLANNER AAI 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) CHARLES GRAHAM JOSEPHINE (UNKNOWN) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent'a Neme/Reletionship (Type, Print) ROBIN L. GRAHAM/STEP-DAUGHTER 8770 MANAHAN DRIVE ELLICOTT CITY, MD 21043 20b. Pieca of Disposition (Neme of cemetery, cremetory or other piece)
BALTIMORE—WASHINGTON
CREMATORY 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any injury or pace. 9/23/98 4 Donetion 5 Dother (Specify) LAUREL, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical Examiner Examiner physician and the bunel-transit The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760. 80 ettending plant for use es 23b. Did tobacco use contribute to the cause of death? Pert ff. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

Physician/Medical by Completed 2

signed by the e peed certificata has t lirector, pege 2 s Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 10 funeral Certification:

1 Yes 2 No 3 Probably 4 Nunknown

24e. Wes en eutopsy performed?

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1 Yes 20 No heck only one)

1 Yes 202 No

Wes case referre	ed to medical				26. Place of D	leath (C/	
examiner?	io	Hospitel: 1 Inpatient 2	ER/Outpefient	3□ DOA	Other: 4 Nursing Home		
7. Manner of Death 1 Naturel 2 Accident	5 Pending investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of fnjury		Injury et Work? 1 Yes 2 No	28d.	
3 ☐ Sulcide 4 ☐ Homlcide	6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	ome, farm, stree	et, fectory, of	ffica	28f.	

Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 Residence 6 Other (Specify)

29a. Certifier

tercertifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and menner stelled.

29b. Signeture end title of on

29a License number

29d. Date signed (Month, Day, Year)

2

Medical

30. Neme end address son who completed cause of deeth (Item 23e) (Type, Print)

1998

110 31. Date filed (Month, Day, Yeer)

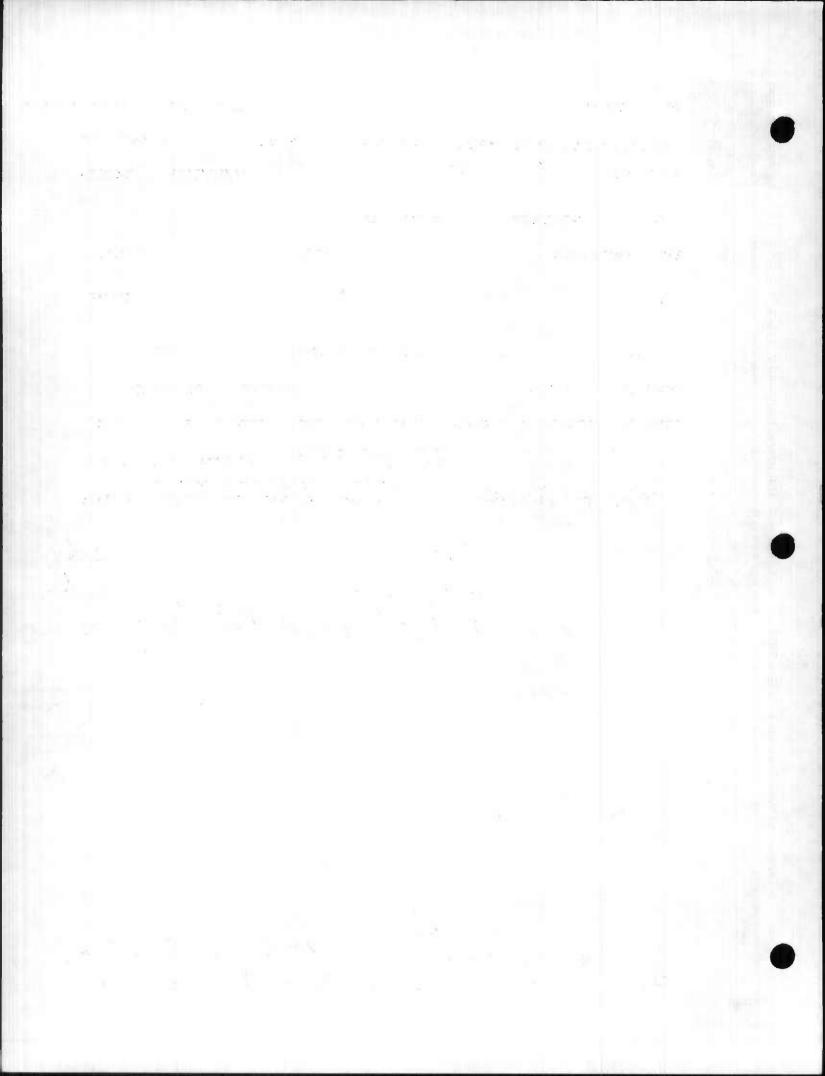
23

32. Registrer's Signature

State Registrar

octor: A

To the To the To the I



105

7. Age (In yrs. last birthday)

10c. City, Town or Location

APT

59

12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

N/A

PITTMAN

If Under Months

Days

21213

1 ☐ Yes 2 ☐ No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

3026 OVERLAND AVE

CLERK

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEM

BALTO

10f. Zip Code

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPT 19, 1998 0645 A GREEN

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

4b. City, Town, or Location of Death

8. Date of Birth (Month, Day, Year)

8-28-39

18. Mother's Name (First, Middle, Maiden Surname)

Date

9-24-98

MARY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4c. County of Death

10g. Citizen of What Country?

U.S.A.

14. Race - American Indian, Black, White, etc.

Specify: BLACK

STATE POLICE

20c. Location - City or Town, State

BALTO, MD

16b. Kind of Business/Industry

UNKNOWN

BALTO, MD 21214

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Ves 2 No

NC

Physician /Medical Examiner

Funeral Director

with the Meryland than "natural", or items 23s or 28s-f show the Wedges Examiner must be notified at "natural", or items 23s deeth

permit. Peges 1 and 2 should be filled within 72 hours effer of Department of Health and Mental Hygiene.
Important: if Nem 27 is marked other than "natural", or han eny injury or other treumatic event, the Medical Estimates

Baltimore, Maryland 21215-0020

physicien end the burief-trensit The law requires that the death certificate be executed Box 68760. for use es signed by the e Records, P.O. been al Division of Vital ā After

Physician /Medical Examiner or Attending Physician: a effer de-el Director: Afr 24 hours To the Hosp within 24 hos To the Fune completely fi

Examiner Physician/Medical á Completed Be Certification: To

5. Social Security Number 216-34-6767 **Usual Residence of Decedent** 10a. State 10b. County Director MD N/A 10e. Street and Number 1125 N. PATTERSON PK AVE 11. Marital Status 1 Never Married 2 Married þ 3 ☐ Widowed ♣ ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) 8 JOHNNY 19a. Informant's Name/Relationship (Type, Print) ANITRA GREEN 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation & Other (Specify) 21. Signature of Funeral Survice Licenses fmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ADELL

4a Facility Name (If not institution, give street and number)

1125 N. PATTERSON PK AVE APT

1□ M 2□F

1 Yes 2 No

Wen-sun

22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO MD 21213 23a. Parf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death (arcinomy of the 12 months Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

Wolfe

M.D. pleted cause of death (Item 23a) (Type, Print)

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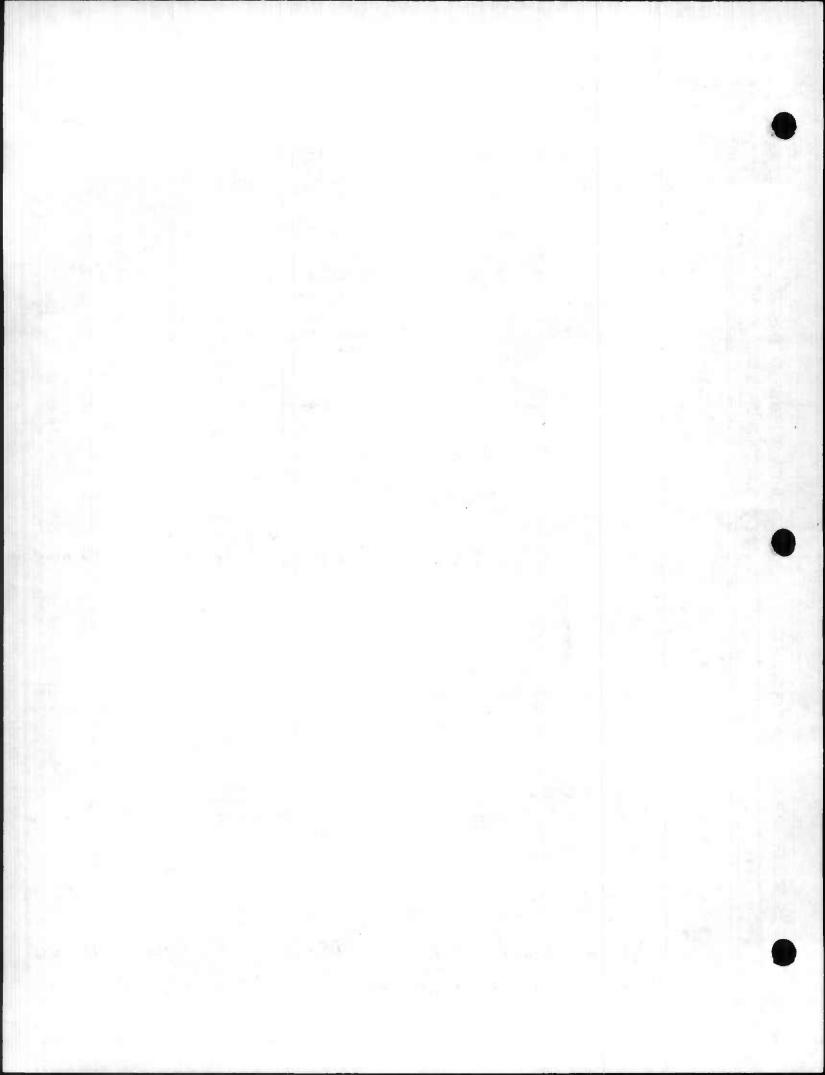
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32 Registrar's Signature

D52257

Street

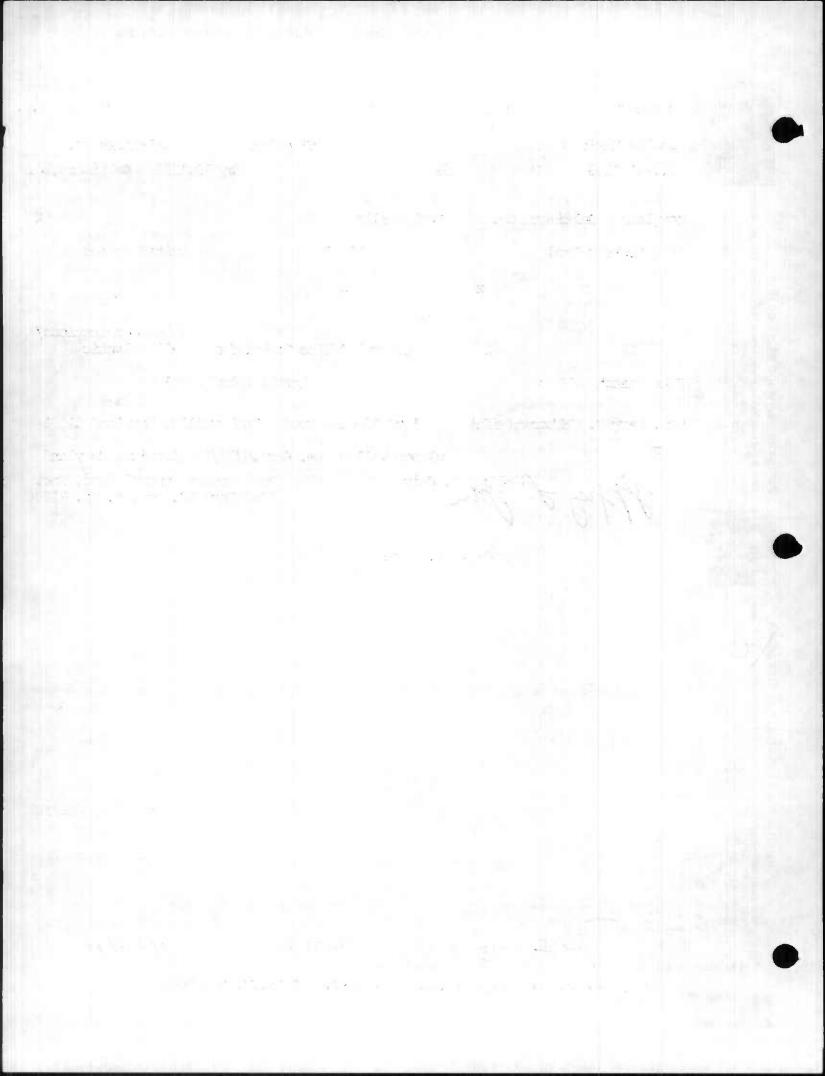
Baltimore,



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3	31-01-4484	1 ⊈ M	2 F	8	6 Yrs.	Months	Days	Hours	Min.	Aug.	14,	1912	Teni	nesse	е
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10	0e. Street and Number					10f. Zip	Coda				100	. Citizan of V	What Coun	ntry?	
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	1 Nevar Married 2 Married 3 Widowed 4 Divorced	ied 1	I ☐ Yas 21☐XN If Yas, Giva Year or Datas:	No		Tas, spec			, rueno	Nicon, an	o.,j	Specify		ite	
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	irs. Virginia H.			e	1012							yland			
20	Oa. Mathod of Disposition			20b. Pla	ace of Dispos matary, cram	sition (Nan	na of	a)	1	Data	20	c. Location -	City or To	wn, Stata	
	1 ☑ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Othar (Sp		oval from Stata		John I				1.	9/23/	98	Hydes,	Mar	yland	
2	21. Signatura of Funaral Servica L	Licensee		-	22.	. Nama an	nd Addras	ss of Facili	y Rue	ck To	wson	Funer	al H	ome,	Inc.
	meland	1	Ruch	/		1050	York	Road				Maryla			
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		State of Marylar		irtment of tificate o			giene 9 Reg. No.	8 29	161
	1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	ath Day	Year 3. Ti	me of Death
Physician /Medical	RICHARD	RAYMOND	0	SEBHARDI	C		per 21,		08 a.m.
Examiner	4a Facility Nama (If not institution, giv	re street and number)			4b. City, Town, or	Location of Deat	4c. County	of Death	
	Stella Maris Hos	piœ			Timonium	n	Balti	imore Co	
Funeral	5. Sociel Security Number 6. S	7. Age (In yrs.		If Undar 1 Ya	ar If Under 24 Hrs	. 8 Date of Bir	th	9. Birthplace (S	tete or Foreign
Director		59 59 59 59 59	Yrs.			May 19	1939	Baltimo:	re,Md.
Pu &	Usual Residence of Decedent 10a. State 10b. County	10c G	ty, Town or Lo	cation				10d Inst	de City Limits
sho sho			Lutherv						Yes 2 No
the N	10e. Street and Number	ore w.	JULIEL V.	10f. Zip Code	•		10g. Citizen of V		Λ
With Page 1	1508 Pickett Road			2109			United		
1215-0020 within 72 hours after death with the Maryland end. then "natural; or items 23s or 23s-1 show in Medical Examinet must be notified at most end of the most end of the contract of the	11. Marital Status	12. Was Decedant Evar in L	J.S. 13. V			Specify Yes or No		a - American Indi	en,
ter d from	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No	H	Yas, specify C	of Hispanic Origin? (S uban, Mexican, Puar	to Rican, etc.)	Blac	k, Whita, atc.	
D2C urs at	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:	1	I□Yes 2€IN	lo Specify:		Specify	White	
2 ho	15. Decedent's Ed	ducation	16e. Deced	lent's Usual Oc	cupation	dia		siness/industry	
215 hin 7	(Specify only highast gra Elementary/Secondary (0-12)		life. E	OO NOT use ret				municat	ions/
21 with displaying the property of the propert	12	College (1-4or 5+)	Cen	tral Of	fice Tech	nician	Bell At	clantic	
Ind 21215-0 be filed within 72 ho tal Hygiene. d other then "nature event, its Mexical Be Completed	17. Father's Name (First, Middle, Last,					me (First, Middle	_	10)	
aryland 212: should be filed within nd Mental Hygiene. marked other than umatic event, the M To Be Comp	John Joseph Gebha	rat			Agatha	Hahn Mo	raul		
Aar 2 sho and 1s m	19a. Informant's Name/Relationship (19b. Meilin	g Address (Stre	eet and Number or R				
iore, N ges 1 and t of Health if them 27 or other tr	Mrs. Mary K. Gebh			Picket	t Road			ryland 2	
Pages 1 Pent of H int: If Ne	20e. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Dam sual from Ctata	cemetery, crem	sition (Neme of netory or other)		Date		City or Town, Sta	
Fag ment bant: D	4 ☐ Donetion 5 ☐ Other (Specif				Mem. Gard				
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, tra Mexical Extra page. To Be Completed by F	21. Signature of Funeral Sarvice Licer	Jeffrey L.	Gair 22	. Name end Ad	dress of FecilityRue			al Home, son, Md.	
	23a. Park. Enjer the disease or com shock, or heart laiture. List only	plications that causad the daa	th. Do not ente	er the moda of o				Appro	ximeta at Between
Physician /Medical		one cause on each line.						Onsat	and Deeth
Examiner	Immediate Cause (Final diseasa or condition resulting In death)	a. ESOPHAGEA	L CANCI	ER					
- T		Due to (or es a conseq	uence of):				1	
min nsit		b						İ	
executed in and in-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or es a conseq	uenca of):					
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8X 5 5	resulting in deeth) Last	Dua to ji	or as a consequ	uerica or).					
P.O. Box 61 nat the darm confector by the sittendary for use Physician/Mex	to the little	d							
da da da da da da da da da da da da da d	Pert tt. Other significant conditions of	contributing to death but not re-	sulting in the ur	nderiving cause	given in Part I.	23b. Dtd	tobacco usa co	ntribute to the co	ause of death?
IS, P.O. es that the da iigned by the a be detached by Physic						10	Yes 2□No	3 Probably	4⊠ Unknown
S, F es tha igned be de be de by F									
(ecords, P.O. Br. law requires that the dammas been signed by the estimates 2 should be detached for included by Physicial						24a. Was	an autopsy ormed?	24b. Were aut	opsy findings prior to
al Record The law require tata has been si page 2 should Completed								completic of death?	n of causa
FRe law The law page 2						10	Yes 2∑No	1 ☐ Yes	2 No
Vital I	25. Was case referred to medicat				26. Place of De	ath (Check only	one)		
of V hysici his ce il direc	examiner? 1 ☐ Yes 2 🔯 No	Hospitat: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA	Other: 4 Nursing	Home 5 ☐ Res	idenca 6 🖾 Oth	er (Specify) H	OSPICE
g Physical dispersion: To	27. Manner of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time of	28c. li	njury at Work?	28d. Describe	how injury occur	red	
atlo	1 Naturat 5 ☐ Pending 2 ☐ Accident Investigatio	n	,,		Yes 2 No				
Division of Vital Records, tal or Attending Physician: The law requires the state death. In Director: After this certificate has been signed in by the funeral director, page 2 should be coertification: To Be Completed by	3 Suicide 6 Could not b		nome, farm, str	eet, factory, offi	ca	28f. Location	(Street and Num t wn, Stete)	per or Rural Route	Number,
Div bal or A al Direction by ed in by			"						
ne Hospital n 24 hours ne Funeral plataly filled		nystctan: To the best of my kniner: On the basis of examina							nuse(s)
2520	one)	and manner stated.							
To the Total	29b. Signatura and title of cartifier	15-			ense number			d (Month, Dey, Y	eer)
. 0	/hr-	- MD		100	13725		7/2	2198	
0	30. Name end eddress of person who								
	DR. TARIQ MAHM			LLEY RD	. TIMONI	UM, MD 2	1093		
State Registrar	31. Date filed (Month, Dev., Yeer) SEP 2 3 1998	32. Registrar's Sign	Lg.	10-1					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Dolores Seplender 20) . Gentry 1998 11:15 p-m /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Church Hospital Baltimore City N/A If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplace (Stete or Foreign **Funeral** Months 1□M 2ØF 218-26-5915 Yrs Feb. 13, 1931 Baltimore, Md. Director 67 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Modical Examiner must be notified at Director 1 X Yes 2 No N/A Md. Baltimore City 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? ò 138 N. Streeper Street 21224 238 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 14. Reca - American Indlen, 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Yeer or Detes: ò Maryland 21215-0020 1 ☐ Yes 2 X No Specify: by Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Be h and Mental Anthony J. Lombardi Helen M. Wink P 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pa a Department of Health a Important: If Item 27 Is any Injury or other traconce. Cory L. Gentry Jr. (Son) 7803 W. Collingham Dr. Baltimore, Md. ore, 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1 ☐ Buriei 2 X Cremation 3 ☐ Removel from State 9/23/98 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Service Corp. Towson 21. Signeture of Funerel Service Licensee Milton JI Knight Jr 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiretory errest, shock, or hear tailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) Examiner Physician/Medical Examiner Surial-transi Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last and Due to (or es e consequenca of) Division of Vital Records, P.O. Box 68760 ata be Due to (or es e consequence of): The law requires that the death pe Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be datach 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes þ Completed 24e. Wes an eutopsy performed? 24b. Were autopsy tindings eveilable prior to completion of cause of death? has 2000 certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician; funeral director Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1□ Yes 2N No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menner of Deeth Certification: 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending Investigation after death. 1 Yes 2 No 24 hours after deat Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and pleca, and due to the cause(s) end menner stated. 29a. Certifier Medica To the within 2. (Check only 29b. Signer a end title of cartitier 29c. License number 29d. Dete signed (Month, Dey, Year) d address of person who completed cause of deeth (item 23a) (Type-Print) MI 32. Registrer's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month Day Year September 20 1998 1250 LORETTA GREEN pm 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) BALTIMORE HOSPITAL AGNES If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth 9. Birthplace (Stete or Foreign Country) MARYLAND 7. Aga (In yes. last birthday) 10 M 20 F Days Hours Usual Rasidanca of Decedant Yrs. State 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No 10g. Citizen of What Country? 10e. Street and Num Was Decedant Ever in U,S Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indien. Bleck, Whita, atc. 1 Navar Marriad 2 Married 1□ Yes 21 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working liffa. DO NOT usa ratired) VEVER WORKED 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Collaga (1-4or 5+) 20b. Place of Disposition (Name of cometary, cramatory or other p 20a. Mathod of Disposition 1 M Buriai 2 □ Cremation 3 DRemoval from Stata 4 Donetion 5 Other (Specify) be difeasa, or complications that causad the deeth. Do not antar tha moda of dylng, such as cerdiac or respiratory errest, it feilure. List only one ceuse on eech lina. BALTU. Onsat and Death Immadlata Cusa (Final disaasa or condition rasulting in daath) FAILURE RESPIRATORY Due to (or es e consequence of) mPHOMA Sequentially list conditions, if any, laading to Immediata causa. Enter Undarlying Causa (Disaasa or injury that initiated avants rasulting in daeth) Lest Dua to (or as a consequence of): Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SCHIZOPHRENIA 24b. Wara autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed? ANEMIA PNEUMONIA 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to madical axaminar? 26. Place of Daath (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 1 Enpatient 2 ER/Outpatient 3 DOA 28d. Dascribe how injury occurred 27. Mannar of Death 28b Time of 28c. Injury at Work? 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicida 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 | Homicide

Physician/Medical þ Completed Be 10 Certification:

Physician

· /Medical

Examiner

Director

Funeral

λq

Completed

Director

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examines must be notified at

2 should be filled within 72 hours after death in and Mental Hygiena.
Is marked other than "natural", or itema 23s

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m

Physician

/Medical

Examiner

any injury or o

Baltimore, Maryland 21215-0020

the Maryland

o the

State Registrar

Medical

29a. Cartifian (Check only one)

29b. Signetura and titla of certifiar

29c. Licanse number

Certifying Phyalolan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

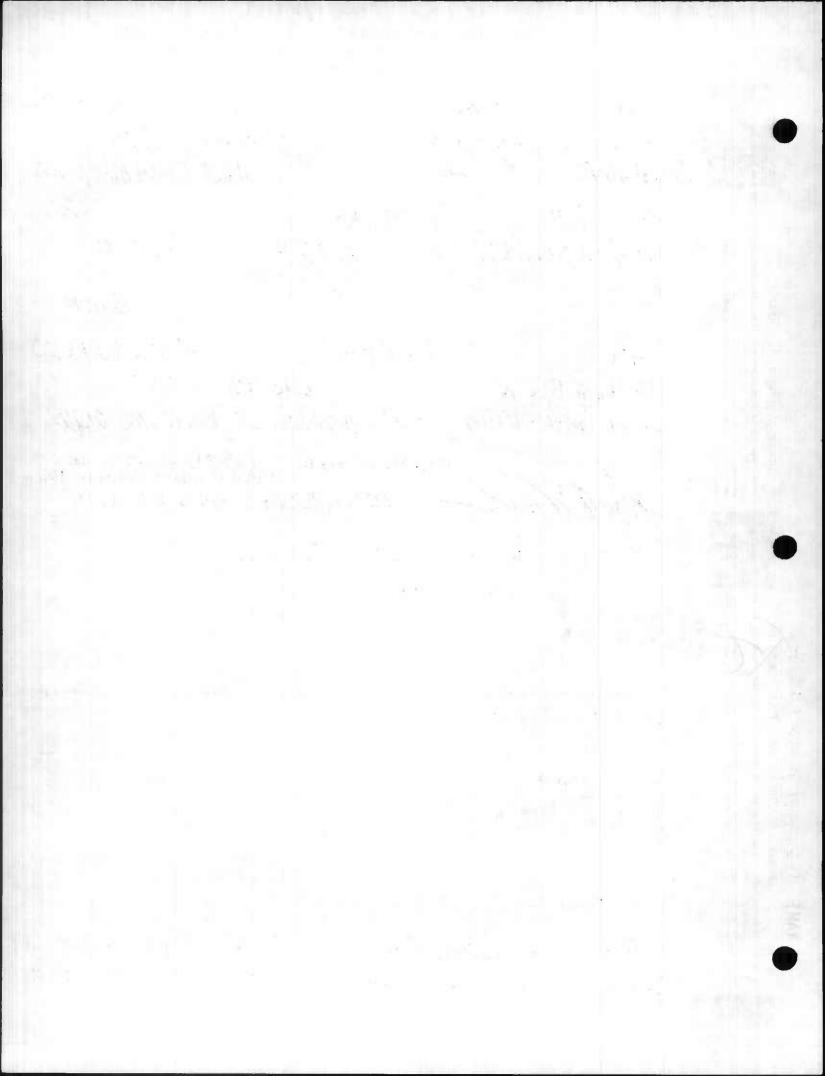
Caton 900

Baltimor, mp 21229

31. Dete filed (Month, Day, Year,

SEP 2 3 1998

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔅 Certificate of Death 1. Decedent's Nema (First, Middla, Last) Month C 2. Date of Deeth 3 Time of Deeth Holmes Yona Marc 0 P 4e. Fecility Nema (If not Institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth St. Agnes Nursing & Rehab Center Ellicott City Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Dev. Y. March 3, 5. Social Sacurity Number Year) 9. Birthpiece (Steta or Foreign County), 1928 Mary Land 6. Sax 7. Aga (In yrs. last birthday) 1□M 2KDF Months Yrs. 70 215-24-7062 Usuel Residance of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6021 Chesworth Road 21228 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Detes: 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16e. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) Collaga (1-4or 5+) Unknown Unknown Paint brush wrapper Glass Mfg. 17. Fether's Neme (First, Middle, Lest) 18. Mothar's Name (First, Middla, Maiden Sumeme) William Grow Helen Stockhausen 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 6021 Chesworth Road, Catonsville, Maryland 21228 R. Gail Fischer / Daughter 20e. Method of Disposition 20b. Pieca of Disposition (Neme of cemetery, crametory or other plece) 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Othar (Specify) Loudon Park Cemetery 9/24/98 Baltimore, Maryland 21. Signature of Fenerel Service Licansee 22. Nama and Address of Fecility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or haart failure. List only ona cause on each lina. Approximeta Intarval Between Opsat and Deeth RDIOMYOPATHY. Immediata Ceuse (Finei diseese or condition resulting in daath) months Due to (or es e consequança of) Dua to (or es e consequance of): Dua to (or es e consequance of): Part II. Other significent conditions contributing to death but not rasultingryn the underlying causa given in Pert i. 23b. Dtd tobacco use contribute to the cause of depth? BSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown DISEASE 24e. Wes en autopsy performed? 24b. Wera autopsy findings

Physician /Medical Examiner

Physician

/Medical

Examiner

.Funeral

Director

28a-f show

6 238

Hems 2

filed within 72 hours effer Hygiene. ther than "natural", or ite

marked other

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy important: If item 27 is marked other any injury or other traumatic event

Baltimore, Maryland 21215-0020

Box 58760

P.0.

Division of Vital Records,

The law requires that the deser-

or Attanding s efter des... al Director: After filled in by 24 hours

Completed by

Be

Certification: To

Medicai

29b. Signeture and title of cartifier

31. Deta filed (Month, Day, Year)

SEP 23

maint be notified at

Director

by

Completed

Be

Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Last

aveileble prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 1 No

25. Wes case referrence examiner?		Hospital:	26. Place of Deeth (Check only one) ospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residanca 6 Other (Specify)								
27. Menner of Death 11 Netural 2 Accident		28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	м	28c. Injury at Work?	28d. Describe how injury occurred					
3 ☐ Suicida 4 ☐ Homicide	6 Could not be datermined		nome, ferm, streatify)	at, fect	ory, office	28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete)					
29e. Certifier (Check only one)	Certifying Ph 2 Medical Exam	yeiclen: To the best of my known the control of the basis of exemine and mennar statad.	owiedge, deeth o etion and/or inve	occurre	ed et the time, date end plecon, in my opinion, daath occ	ea, end dua to tha causa(s) end menner es steted. currad et the time, dete end piace, and dua to tha cause(s)					

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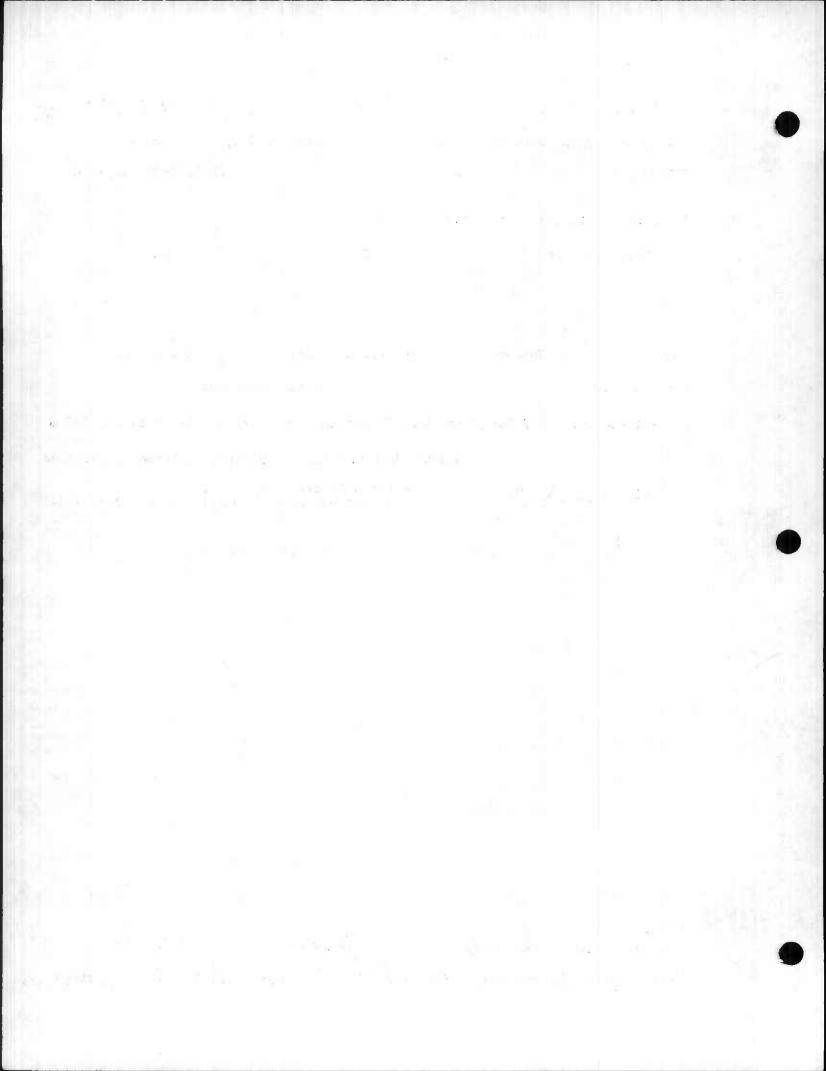
32. Registrar's Signeture

29c. Licanse number 29d. Dete signed (Month, Dey, Year) D 28595 98

30 Neme end eddress of person who complated cause of deeth (Itam 23a) (Type, Prin) SNEEM 7220

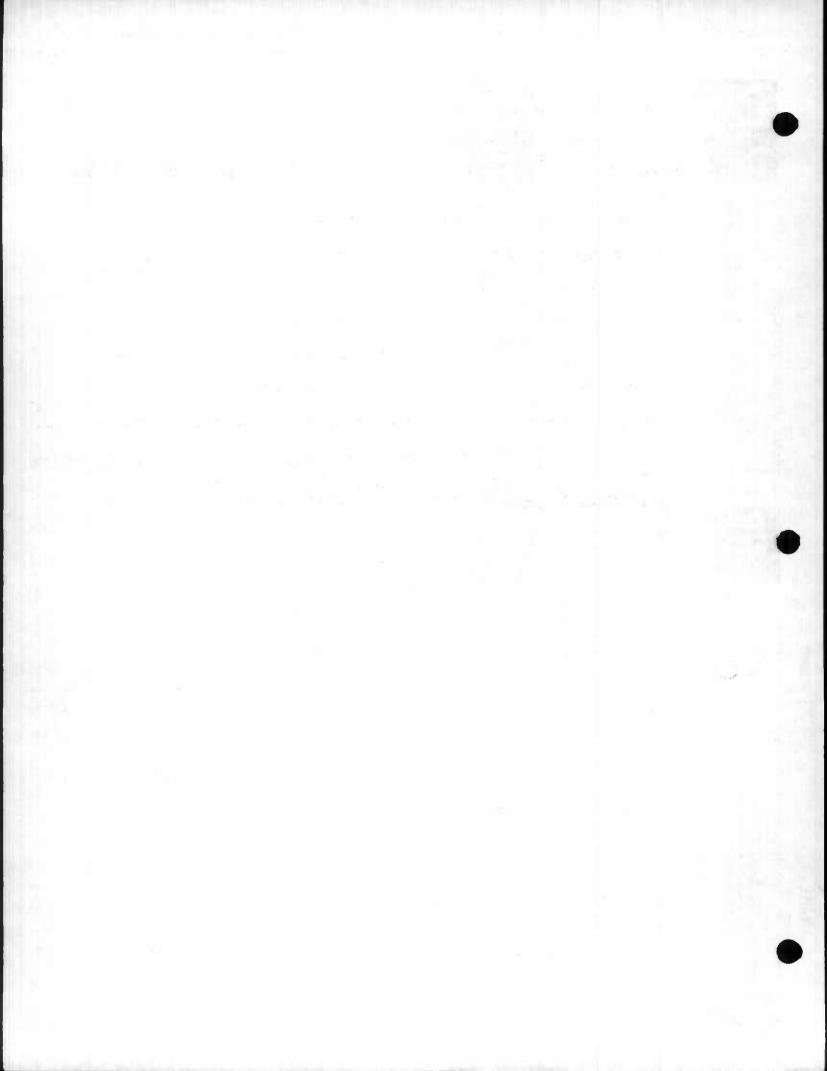
State Registrar

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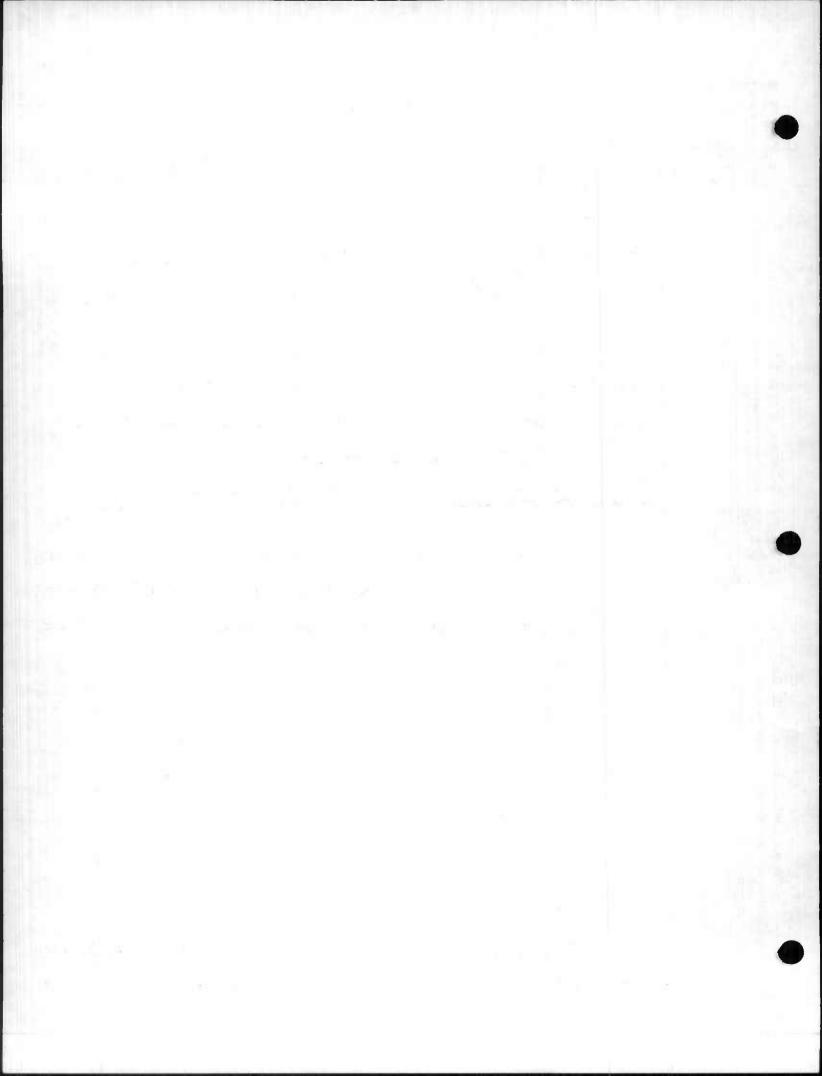
State of Maryland / Department of Health and Mental Hygiene Q

					Cei	rtificate	of L	Death	,	Reg. No.	0 6	3165
Physic		1. Decedent's Name (First, Middle, Last)	1					2. Dete of De	eth Dev	Yeer	3. Time of Death
/Medi		Frank Mitchell He	rold						Sertens		1998	0235
Exami	ner	4a. Fecility Name (If not institution, give					41	b. City, Town, or	Location of Deat	11.	y of Death	
		St. Agner	1to sp					Balt	more		Ut'u	rove
Funeral Director		5. Social Security Number 218-12-8166 Usuel Residence of Decedent	x 7. Aq M 2□ F 7		last birthday) Yrs.	If Under 1 \ Months D	eys	Hours Min.	(Month, De	th ey, Year) 3, 1920	9. Birthple Country Mary 1.	ce (Stete or Foreign y) and
laryland show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					100	d. Inside City Limits
the Maryla 28a-f shorn	to	Maryland Baltimore	2	Ba	ltimor	e Highl	and	de				1 ☐ Yes 2 🂢 No
r 28a-f	2	10e. Street and Number			LCIMOL	10f. Zip Co		40		10g. Citizen of	Whet Countr	y?
death with the Maryland ms 23a or 28a-f show	alD	4126 Annapolis Roa	ad, 2-B			21227	7			USA		
or he	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 X If Yes, Give Yeer or Dates:			Was Deceden 1 Yes, specify 1 □ Yes 2X		spenic Origin? (S n, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	city Yes or No- Rican, etc.) 14. Rece - A Bleck, W Specify: WI		c.
72 hours	Completed	15. Decedent's Edu	cation		16a. Deced	lent's Usual C	ccupa	tion	4.1	16b. Kind of B		
within 7	ple	(Specify only highest grad Elementery/Secondery (0-12)	College (1-4or	5+)	life.	DO NOT use r	retired)	uring most of wo	rking			
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Maryland 2 d 2 should be filed v th and Mental Hygie 7 is marked other t traumatic event, to	Be	17. Father's Neme (First, Middle, Last)						18. Mother's Na	me (First, Middle	, Meiden Sumer	ne)	
Ment Went	2	William Herold						Leona G	able			
s 1 and 2 should f Health and Mer fem 27 is mark other traumatic		19a. Informant's Neme/Reletionship (T)	rpe, Print)		19b. Mailir	ng Address (S	treet e	nd Number or R	ural Route Numb	er, City or Town	, Stete, Zip C	Code) 21227
and alth		Helen M. Herold /	Wife		4126 A	Annapol	ĺs	Road, 2	-B, Bali	timore H	lighla	nds, Md.
Defiliriore, in semit. Pages 1 and Department of Health important: If New 27 any Injury or other trans.		20e. Method of Disposition		20b. P	lace of Dispo	sition (Neme	of		Dete	20c. Location		
Saltimore, emit. Pages 1 a Pepariment of Hea mportant: If Item: iny Injury or other MCs.		1 N Buriel 2 □ Cremetion 3 □ F 4 □ Donation 5 □ Other (Specify)						al Park	9/21	Glen Bu	ırnie.	Maryland
permit. Page Department Important: If any Injury or once.		21. Signature of Funeral Service Licens			-	. Name end A				0		
Department of the population o		Hack il	XIII		I	lubbard	Fu	ineral H	ome, Ind	2.		and 21229
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/Medical		Immediate Cause (Fine)	PI	100		1	_		104 0		i	1 1 -
Examiner		disease or condition resulting in death)		Cary	nse		a	1 CINC	MCG			1 year
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petra pa	늍)		r es e conseq	1 - 00	u	213		-		2 weeks
esecul m and tal-trar	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		D09 10 (0)	es e conseq	derice or).					-	
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d by the	ys	Part II. Other significent conditions cor		ut not resu	liting in the u	nderlying caus	e give	n in Pert I.				he cause of death
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aff : The cate h									10	Yes 2 No	1 🗆	Yes 2 No
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After this forestid	OU:	27. Menner of Death 1. ■ Neture 5 Pending	28e. Dete of Inju (Month, De	y Year)	28b. Time of Injury		Injury Work		28d. Describe	how Injury occur	rred	
Attending ir death. ector: Atla by the fund	cati	2 Accident Investigation 3 Sulcide 6 Could not be				М	1 🗆 Y	es 2□No				
To the Hospital or Attending Physician: The Within 24 hours state death. To the Funeral Director: After this certificate completely filled in by the funeral director, pa	Certification:	4 Homlcide determined	28e. Place of Inj building, et	28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)						Street end Num wn, Stete)	ber or Rurel I	Route Number,
Hosp Wines	edical	29e. Certifier Certifying Physical Check only 2 Madical Examin	lcien: To the best	of my know	wiedge, death	occurred at the	he time	e, dete and plece	e, end due to the	cause(s) end m	anner as stat	ted.
and and and and and and and and and and	8	uie,	end manner st	ated.								
To To	Σ	29b. Signature end title of certifier						number		29d. Date signe		
		I mit	leas	NOU) .	PI	ク	597	<	gepten l	er k	1998
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10			AD. St. A	sier	Hospita	1 ,900	Cat	on Avenu	e Raltin	love IVI	andan	3, 1998 I 21729
Sta	te	31. Date filed (Month, Dey, Year)	JZ. Megisti	ar's Signe	ture &	1		11	-,	1	9-91	
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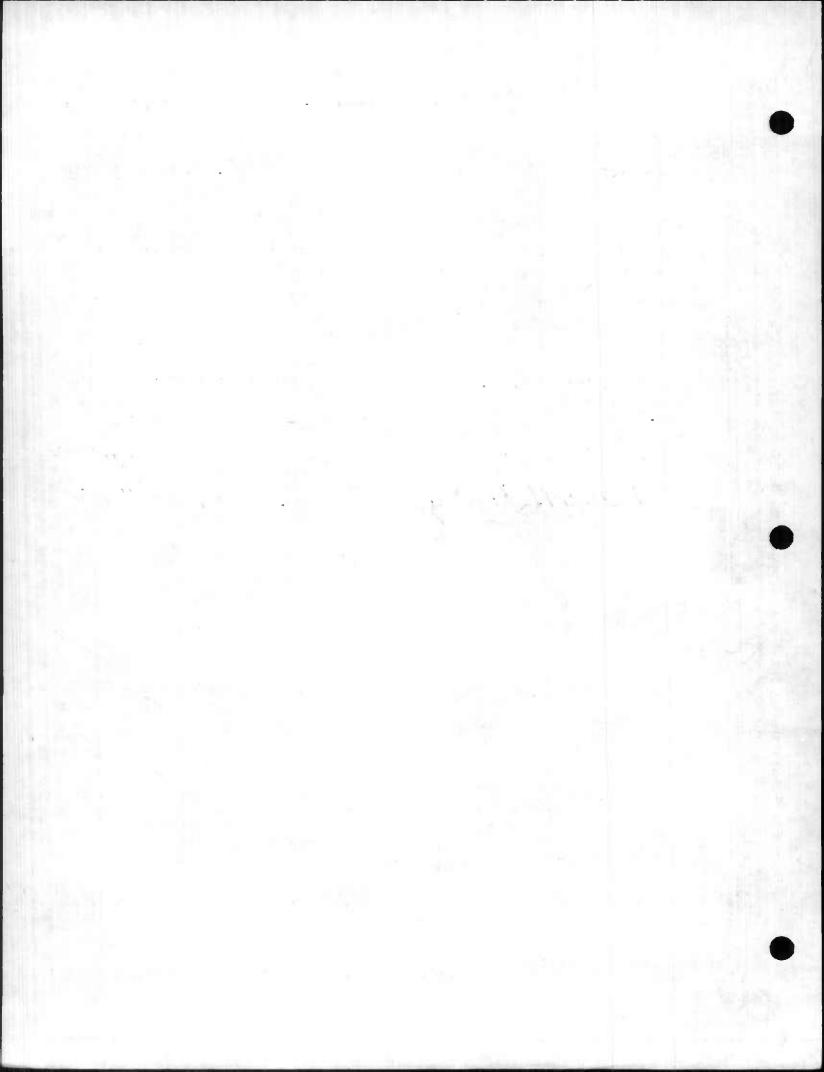
	1.	Decedent's Name (First, I	Aiddla, Las	1)		Oei	arroc	ile of	Death	2 Date of D	Reg. No.		3. Tima of Death
ician dical		RYAN				H/1	12			Sel Ten	BER 21	Year 1990	1208 P
iner	5.	Facility Nama (If not instruction of the Social Security Number 212–17–2014 stall Residence of Deceder	6. Se	PKINS		last birthday) Yrs.	A L If Und Month	ler 1 Year	BALTIN If Undar 24 Hrs. Hours Min.	ORE 8. Date of B	irth	9. Birth	nplace (Stata or Foreign untry) Carolina
_		a. Stata 10b. Co			10c. Ci	ty, Town or Lo							10d. Inside City Limits
Director	10	MD. How	ard			Columb	_	ip Code			10a Citizan	4 Milhat Ca	1 ☐ Yes 2√√ No
Ö	"	8401 Freedom	Cour	t			101. 2	2104	6		U.S.		untry?
by Funeral	•	. Marital Status 1 Nevar Married 2 3 Widowed 4 Divo		12. Was Decedant (Armed Forces? 1 Yas 2 No. (1) Yas, Give Yaar or Dates:	,	In U.S. 13. Was Decedent of				pecify Yes or No Rican, etc.)	14. R		
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eva dot	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide										ame)		
	19	e. Informant's Name/Rela							and Number or Ru				
D	Donald E. Hines, father 10720 Bridlerein Terrace, Columbia, Md. 21044 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10720 Bridlerein Terrace, Columbia, Md. 21044 20b. Place of Disposition (Name of cametery, crematory or other place) Baltimore Washington Crematory Laurel, Md.										Town, Stata		
an/Medical Examiner	In di re	3a. Part1. Enter the diseas shock, or heert failure. In mediata Causa (Final sease or condition sulting in death) sequentially list conditions, any, leading to immediate uses. Enter Underlying ausé (Disease or injury at initiated events sulting in death) Last	List only o	a. VENO: STATUS C. AUTE	Due to (c	CLUS or as a consequence of the	Poly June Co	2 - n: 15 h n: TIC.		E TRAN		Te	Approximate Interval Between Onset and Death 3 WEEKS 5 WEEKS
Physician/M	Pa	rt II. Other significant cor	ditions cor	ntributing to death bu	ibuting to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause 1 ☐ Yes 2 No 3 ☐ Probably 4		
Completed by											s en eutopsy formad?	8	Were autopsy findings wallable prior to complation of cause of death?
Con										10	Yes 2X No	1	☐ Yes 2☐ No
) Be	25	. Was case referred to me examinar? 1 ☐ Yes 2 ☑ No	_	Hospital:				Oth	26. Place of Dea				
Tigenpatient 2DEMOutpatient 3DDA 4D Nursing Homa 5D Hesider									nity)				
Certification:		4 ☐ Homicide de	termined										
edical	29	a. Certifier to Cert (Check only one)	Ifying Phydical Exami	elclan: To the best o ner: On the basis of and manner sta	examine	wledge, death tion and/or Inv	occurre	d at the tin on, in my o	ne, dete and plece pinion, deeth occu	, end due to th rred at the time	e cause(s) and o, dete and plec	manner as e, end due	stated. to the cause(s)
×	29	b. Signature and title of ce	rtifier		1			9c. Licans			29d. Date sig	ned (Month	n, Day, Year)
		Tamara	Bld	yus				KES	000		SEPTEN	BER	21 1998
State strar		Name and address of per AMARA DIV. Date filed (Month, Day, Y	Pa	32. Registra	Z ir's Signa	JOHNS	Print)	TOPK	INS H	DSPIT	AL	BALT	21 1998 IMORE MI

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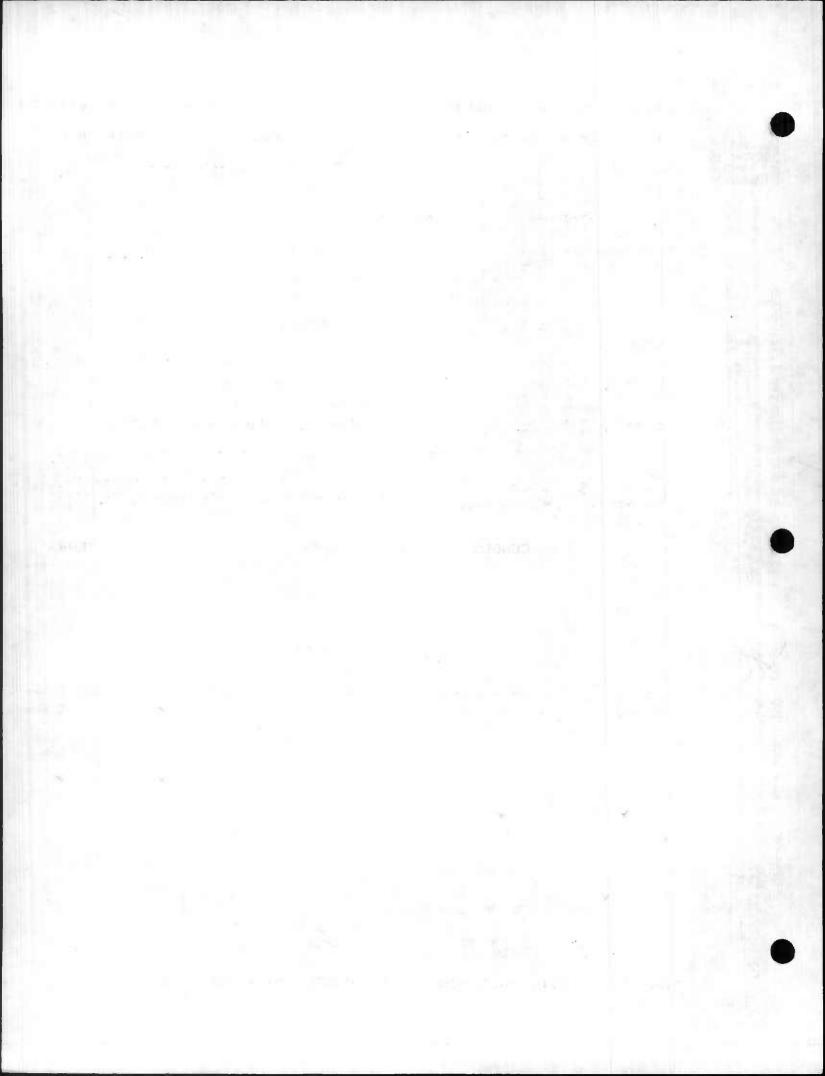
State of Maryland / Department of Health and Mental Hygiene 98 29 | 67

				Cei	titica	te of l	Death			Reg. No.			
	1. Decedent's Name (First, Middle								2. Date of De		Vana	3. Time of Death	
Physicia		Floy	d McK	Cinley	Hick	ks, J	r.		Septemb	per 22,	1998	4:35 AM	
/Medica	An English Stome Wand Indianting	give street end nu	mber)	17.7		14	b. City, To	wn, or Lo	ocation of Death				
Examine	6516 Baltimore							ndal		,	timor	re	
		6. Sex	7. Age (In yrs.	last hirthday)	If Unde	r 1 Year	If Under						
Funeral		1(2XM 2□ F		Yrs.	Months	Months Days Hours Min.			8. Date of Bird (Month, Da Aug. 25	y, Year)	Coun	lace (Steta or Foreign	
Director	234-40-3312 Usual Residence of Decedent		70						Aug. 2:	, 1928	ATI	gînia	
2	10a. State 10b. County 10c. City, Town or Location										1	0d. Inside City Limits	
aryle aryle			100.0	.,,	041011							1 ☐ Yes 21 No	
M Party	Maryland	Baltimo	re				Dun	dalk				1 1 162 2 KJ NO	
5 6	Maryland 10e. Street and Number				10f. Zij	p Code				10g. Citizen of V	/hat Coun	try?	
h wi		Avenue					2122	2		United	Stat	tes	
deed man	6516 Baltimore 11. Marital Status 1 Never Married 2 Married		edent Ever in U	J,S. 13. \	13. Wes Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, atc.						e - Americ		
D and and I			20 No					, Puerto	Hican, atc.)	Blac	k, Whita, e	etc.	
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Iryland 212 should be flied withing Mental Hygiene, america other than matic event, the the	Floyd McKinley						Little	ici EV	cayn ne	тиотей			
	19e. Informant's Name/Relationsh	ip (rypo, rimit)	Wife	19b. Meilin	ng Addres	s (Street	and Numbe	or or Run	al Route Numbe	er, City or Town,	Stete, Zip	Code)	
CENL	Mrs. Mary Kathe	erine Hic	ine Hicks 6516				e Ave	nue	Dunda:	lk, Mary	land	21222	
	20a. Method of Disposition			Plece of Dispo	sition (Na	me of	oal .		Date	20c. Location -	City or To	wn, State	
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it. P	4 Donation 5 Other (Sp		Oa	k Lawn				1	72550			**	
Dealth Permit. Departm Importa eny inju	21. Signature of Fundual Service Licensee . 22. Name and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc.											nc.	
_ 40.200	7922 Wise Ave. Dundalk, Maryland											1222	
	23a. Part1. Enter the disease, or complications thet caused the death shock, or heart failure. List only one cause on each line.									1	Approximate Interval Between		
Physician										1	Onset and Death		
/Medical	Immediate Cause (Finel	Immediate Cause (Finel disease or condition Me tastatatic Gastaric Concer								1	2mo.		
Examiner	Immediate Cause (Finel disease or condition resulting in deeth) a. Metastatic Gastric Cancer									1	2		
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184 67	that initiated events rasulting in death) Last Due to (or as a consequence of):												
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at the diby the etache	Pert II. Other significant condition	e contributing to o	oatii oot iiot iot	solary at the or	ilderlying i	cause giv	on an anci.		23b. Did tobacco use contribute to the cause				
det de de de de de de de de de de de de de									10	Yea 2 No	3 Proc	bably 4 Unknown	
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vical necorional pictures of certificate has been si rector, page 2 should be	25. Was case referred to medical						26. Place	of Deat	h (Check only o	ne)			
Physician: this certifical director,	O 1 Yes 2 No	Hospitel:	Inpatient 2	ER/Outpatien	t 3 D	OA Oth	or:			dence 6 Other	or /Sneak	w)	
eld sign		28a. Date		28b. Time of		UA	4 LI NU	-		now injury occurr		77	
After Tune	1 ☑ Natural 5 ☐ Pending	(Mon	th, Day Year)	Injury	м	28c. Injun Worl	k? Yes 2⊡I			,,			
or Attending P. after death. I Director: After tid in by the funera	27. Manne of Deeth 1 © Natural 2 Accident 1 vastig 3 Suicida 4 Homicide determine	ot be					103 2		00/ 1	D4 - 14 - 15		10: 4: 11	
r Ar Ar Ar Ar Ar Ar Ar Ar Ar Ar Ar Ar Ar	4 Homicide determine	ioma, farm, stri	eet, factor	y, office			28f. Location (S City or Tox	Street and Numb vn, Stete)	er or Hura	Houte Number,			
3500													
houn hour life	29a. Cartifier 1 Certifying	Physician: To the											
Fu Pere	29a. Cartifier 1 Certifying (Check on) 2 Medical E	xaminer: On the b and man	asis of examina ner stated.	ation and/or inv	estigation/	n, in my of	pinion, deal	in occurr	ed at the time,	date end placa, a	and due to	tne cause(s)	
omp omb	29b. Signature and title of certifier	1			29	c. License	number			29d. Data signed			
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Lall 1	0 1301												
1077	30. Name and address of person w	ho completed caus	se of death (Ite	m 23a) (Type,	Print)	40	26-	00	Time	DRE ,	na o	11237	
Y	and willing) 6830) 1105	小 (HL <	- >NC	# 2	00	or	I L CTIVU	ر حال	100	-3-1	
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State of Maryland / Department of Health and Mental Hygiene

Decedent's Nama (First, Middla, L CHARLES LOU!) Facility Nama (If not institution, gi		EIN	SR		C	2. Data of Deal Month	Day	Year	. Tima of Death	
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Facility Nama (If not institution, ga			100 F V		3	Ch. LEMBE	K 21,1	998 1	0:40 PM	
Saint Joseph			er		4b. City, Town, or TOWS	on	4c. County	of Death Baltim	ore	
216-01-0494	Sex 7. Ag 123-M 2□ F					(Month, Day	, ^{Year)} 4, 1915	(ear), 1915 9. Birthplace (Stata or Foraign Country) Md.		
		10c. City	, Town or Loca	ation				10d.	Inside City Limits	
Md. Baltim	ore	Re	isterst	רועוס־				1 □ Yas 2 No		
			200020		ode	1	0g. Citizen of	What Country?		
10 Mission Wood	Way				21136		U.	S.A.		
1. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☼ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yas 2 H Yas, Giva Yaar or Datas:	Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva			_	Specify Yas or No- to Rican, atc.)	Bla	ck, Whita, atc.		
15. Decedent's E	ducation		16a. Decede	nt's Usual (Occupation	rkina	16b. Kind of B	usiness/Indust	ry	
Elementary/Secondary (0-12)		5+)			retired)					
10	45		Buy	rer	[40 At W. J. M.	a delina delinata				
	•				1		Aaiden Suman	na)		
			10h Mailine	Addman (0	City of Town	Otata Zin Co.	de l	
									10)	
	, Jr. Son	20b. Pl	ace of Disposit	tion (Name	of				Stata	
		1				9/25/98	Reiste	rstown	. Md.	
Kam B	F1-	11824 Reisterst								
3a. Part1. Enter the disease, or cor	nolications that cause	d tha daath							proximata	
which, or heart failure. List only	one cause on aach li	na.						trit. On	arvat Between aset and Death	
nmediata Causa (Final	CONGESTIVE HEART FAILURE YEARS									
	aDua to (or as a consequence of):									
equentially list conditions, any, taading to immediata ause. Enter Underlying	as a conseque	ence of):				1				
lat miliated events	as a consequa	ence of):	44							
	d									
art II. Other significant conditions	contributing to death b	out not resu	Iting in the und	lertying cau	sa given in Part I.	23b. Did to	23b. Did tobacco use contribute to the cause of deat			
ACUTE RENAL	FAILURE					1 U Y	● 2 No	3 Probab	ly 4 Unknow	
						24a War a	n autoney	24b. Wara	autopsy findings	
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							n Pan		as 2011 No	
5. Wee case referred to mediant					80 Bl-			1014	15 26 NO	
axaminer?	Hospital:	ant all	EB/Outnoticet	3 🗆 🗠	Other			or /Consite		
			28b. Time of	1		_				
		y Year)	Injury	М	1 Yes 2 No	550				
3 Suicide 6 Could not determined	t be 100 Throat the state of th							ber or Rural Ro	outa Number,	
9a. Certifier 1 Certifying P (Check only one)	miner: On the basis o	f axamineti	vledge, death o ion and/or inve	occurred at stigation, in	the tima, data and place my opinion, death occ	e, and due to tha curred at the time, d	ause(s) and mate end place,	anner as state and due to the	d. cause(s)	
9b. Signatura app titla of certifing	-0	(Tal)				2	9d. Data signe	d (Month, Day	, Year)	
100317	TIM	M(1)		D2	4034		9	2219	18	
	11 11 11	110	6				L.	-		
). Nama and addrass of person who	completed cause of o	leath /Item	23a) (Type P	rint)			1	1		
	Sual Residence of Decedent	Susual Residence of Decedent	Sequentially list conditions, any, leading in death) Last III. Other significant conditions suiting in death) Last III. Certifying Physician: To the basis of axaminet and menore of Death Last III. Certifying Physician: To the basis of axaminet (Check only one) 20 Medical Examiner: To the basis of axaminet: Complex of menore of Death Last Office of a complex of physician: To the basis of axaminet: Complex of physician: To the basis of axaminet: Complex of physician: To the basis of axaminet: Complex of physician: To the basis of axaminet: Complex of physician: To the basis of axaminet: Complex of physician: To the basis of axaminet: Complex of physician: To the basis of axaminet: Complex of the physics of the physics of the physics of the physics of the physics of the physics of the physics of the physics of physician: To the basis of axaminet: Complex of the physics of physics of the physic	Security Security	Street Residence of Decedent Statia 10b. County 10c. City, Town or Location Md. Baltimore Reisterstown 10f. Zip Co. Street and Number 10f. Zip Co.	216-01-0494 18-M 2 F 83 Yrs. Months Days Hours Min.	216-01-0494 10	216-01-0494 12M 20F 83 Vrs. Monthle Deys Hours Mm April 124, 1915 83 Vrs. Monthle Deys Hours Mm April 124, 1915 83 Vrs. Monthle Deys Hours Mm April 124, 1915 83 Vrs. Monthle Deys Hours Mm April 124, 1915 10c. City, Town or Location Reisterstown 10 Mission Wood Way 10 Mission Wood Way 11 Marrial Status 12 Was Dependent of Hageas Cology? (Specify Year or Now-West Process) 13 Was Dependent of Hageas Cology? (Specify Year or Now-West Process) 14 Was Dependent of Hageas Cology? (Specify Year or Now-West Process) 15 New Harried 2 Married 2 Married 12 Married	216-01-0494 IDAN 22 F 83 Vrs. Months Days Hours Min. April 14, 1915 Control	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 5ep lember 7 4b. City, Town, or Location of Death 4c. Cou Helen Agnes Kirkner 4e. Fecility Neme (If not institution, give street and number) 4c. County of Death St. Agnes Hospital Baltimore N/A If Under 24 Hrs. 8. Defe of Birth (Month, Dey, Yea 7. Age (in yrs. last birthday) 92 Yrs. If Under 1 Yeer 5. Social Security Number Birthplece (State or Foreign Country) Months Deys 10M 2DF 220-05-9744 Mar. 7, 1906 Maryland Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥ Yes 2□No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 35 N. Lakewood Avenue 21224 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Defes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 □ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Seamstress Bernard Land Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Frank Burdynski Elizabeth Czykowski 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 715 Maiden Choice Lane Pv 407 Catonsville, MD 21228 Constance Southerington 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Burlei 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 9-22-98 Baltimore, MD Holy Rosary Cemetery 21. Signeture of Funeral Service Light Moran-Ashton-Dabrowski Funeral Home, Inc. 3000 E. Baltimore Street Baltimore, MD 21224 are or complications their caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, e. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediete Ceuse (Final monar diseese or condition resulting in deeth) Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In deeth) Lesf 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 2 X No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

20

Completed

2

Funeral

Director

item 27 is marked other than "natural," or items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after in Department of Health and Mental Hyglene. Important: if item 27 is merked other than "natural; or the any injury or other traumatic event. Its Mantalant is served.

Maryland 21215-0020

Baltimore,

the Meryland

death

Physician/Medical

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by this certificate has Certification: After death. Director:

Helen

AME

State Registrar

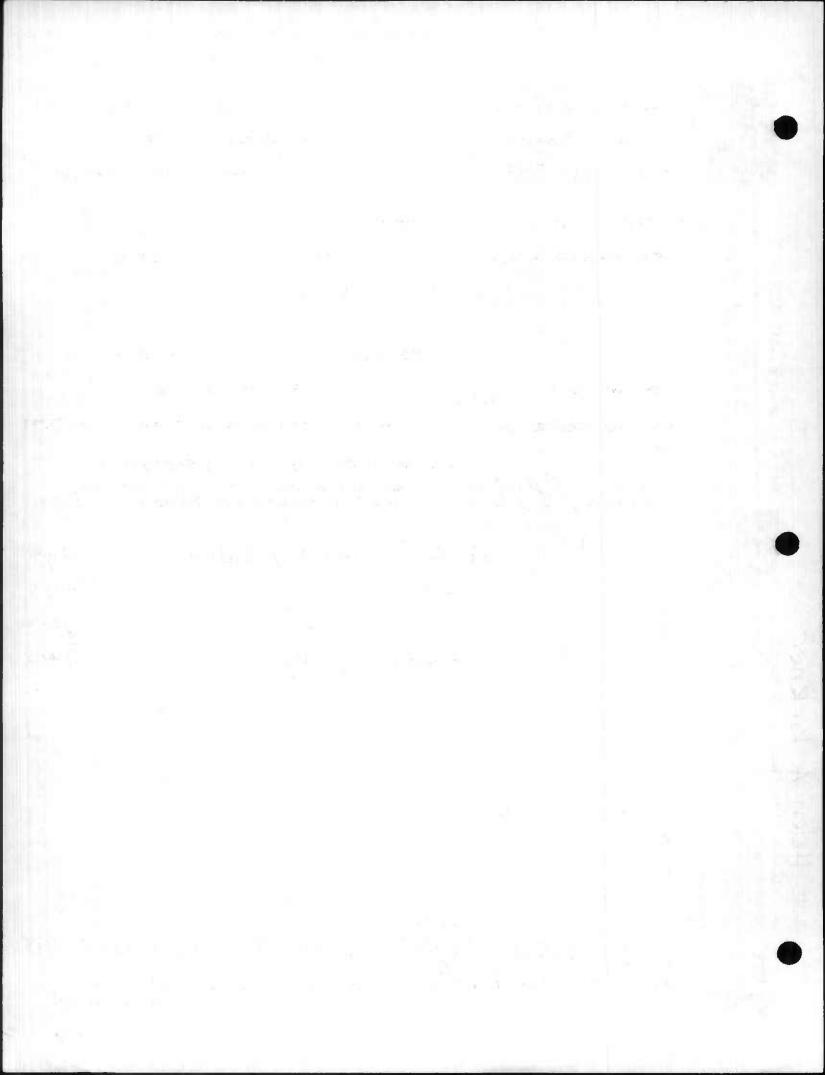
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29a. Certifier

29b. Signature and Mile of certifier

29d. Date signed (Month, Dey, Yeer)

31. Dete filed (Month, Day, Yeer) Registrer's Signeture 3 1998

To the Hospital within 24 hours a To the Funeral D



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month September 22 19981:35A.M **Physician** Marie Kirby Johanna /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Nema (If not Institution, giva street and number) Examiner Baltimore Center Osedale If Under 24 Hrs. 8. De 7. Age (In yrs. last birthday) Franklin Square Hos If Under 1 Year Birthplace (Stata or Foreign Country) 5. Social Sacurity Number 8. Deta of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 🖺 F 80 Director 216-01-2654 Maryland Usual Rasidence of Decedant 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23a or 28a-f ahow 1 ☐ Yas 2 No Directo Baltimore Md 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 105 Kenilworth Park Drive 21204 USA Funeral 12. Wes Decedent Ever in U,S. Armad Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Black, Whita, atc. Pages 1 end 2 should be filed within 72 hours after nent of Haalth end Mantal Hygiena. 1 Yes 22No If Yas, Giva Yaar or Dates: 1 □ Navar Married 2 □ Married 1 Yas 2 No Specify: þ 3 ☐Widowed 4 ☐ Divorcad White Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Supervisor John Hopkins University 12 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fethar's Nama (First, Middle, Last) Theodore Reichhart Marie 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Department of Haalth e Important: If Item 27 is any injury or other tra Mary C. Corbin 7438 Bradshaw Rd., Kingsville, Md. 21087 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 memoval from Stata Hilltop Serv. Corp. 9/23/98 Towson, Maryland 4 □ Donation 5 □ Other LSpa 22. Nama and Addrass of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. Ernes Feist III 23a. Part1. Ental tha disaasa, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediata Causa (Final disaese or condition rasulting in daath) Respiratory /Medical Examiner Dua to (or as a consequence of) Examine Disease end -trans Sequantially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disaasa or injury that initiated events Dua to (or es e consequence of) physician the burial Hepa Physician/Medical Dua to (or as a consequanca of) rasulting in death) Lest 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 1 Yes 3 Probably 4 Unknown b 24b. Ware autopsy findings availabla prior to complation of cause of daath? should l 24a. Was an autopsy parformed? Completed s certificate has director, page 2 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical axaminar? Be 26. Placa of Death (Check only one) axaminar? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 this 28d. Describe how Injury occurred 27 Mannar of Deat 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accidant 5 Panding invastigation 1 Yas 2 No Director: A 6 Could not be determined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, streat, fectory, offica building, atc. (Spacify) • Funeral Directions of the Funeral Direction 4 Homicida 10 Certifying Physician: To the bast of my knowledge, death occurred at tha tima, data and placa, and due to tha causa(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and placa, and dua to the cause(s) and manner stated. 29a. Cartifiai edicai within 2 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. Licensa number

with the Maryland

deeth \

be executed

The law requires that the

or Attending Physician:

Division of Vital Records, P.O.

September 22, 1998

30. Nama and eddress of person who completed causa of daath (Itam 23e) (Type, Print)

9000 Franklin Square Drive Ballimore, Mary End 21237 Madai hardon 31. Data filad (Month, Day, Yaar) 32. Registrar's Signatura

Registrar

State

Region of the partition of the collection in the property of the state of the st

98-5512-510 WESLEY KOFFKEY ASP

Please Type or Print In Black Indelible Ink. Assure All Copies Are LegIble.

State of

Maryland /	Department of Health and	Mental Hygiene
	Certificate of Death	Reg No

3. Time of Death 1998 3:06 A

N/A

Maryland

White

21219

Approximate Interval Between Onset and Death

24b. Were autopsy findings evailable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

ches

111 Penn Street, Baltimore, Maryland 21201

Black, White, etc.

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

filed within 72 hours efter traumatic svent, the Medical Hygiene. other Pages 1 and 2 should be file ment of Health and Mental Hyant: If flem 27 is marked othoury or other traumatic sventury or other traumatic sventury. important: If its any injur

Baltimore, Maryland 21215-0020

P.O. Box 68760 950 ed by the signed be del Division of Vital Records, page 2 hes certificate this

> completely f within 2 To the To the

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Wesley Richard Kofskey, Sr. SEPTEMBER 20 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner BAYVIEW HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys 15xM 2□ F Months Hours 32 216-84-8482 Director Aug. 18,1966 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location "natural", or items 23s or 28s-f show bolical Expresses must be notified at Edgemere Directo Baltimore Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21219 United States 7236 North Dakota Ave. Funeral death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, 1 ☐ Yes ※2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Serviceman 12 Years 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carleen May Harrison William Roland Kofskey, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. tnforment's Name/Reletionship (Type, Print) Edgemere, Maryland Mrs. Carleen Sievers (Mother) 2819 Wells Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State Holly Hill Mem. Gdns. 9/23/1998 Middle River, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signeture of Puneral Service Licensi Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequer ca of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à 24a. Was en eutopsy Completed performed? 1 ☐ Yes 200 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1. Yes 2□ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 35 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Menner of Death 28b. Time of Injury 28d. Describe how Injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? prosper 1 Naturel 5 Pending efter death. Director: Aft 2034M 1 Yes 2 No Q.20.98 investigation 2. Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Street 24 hours e Hospital 29a. Certifier Medical and manner stated.

vehicle 28f. Location (Street and Number or Rural Route Number, City or Town, State) nech owythe AVES. 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) and menner es stated.

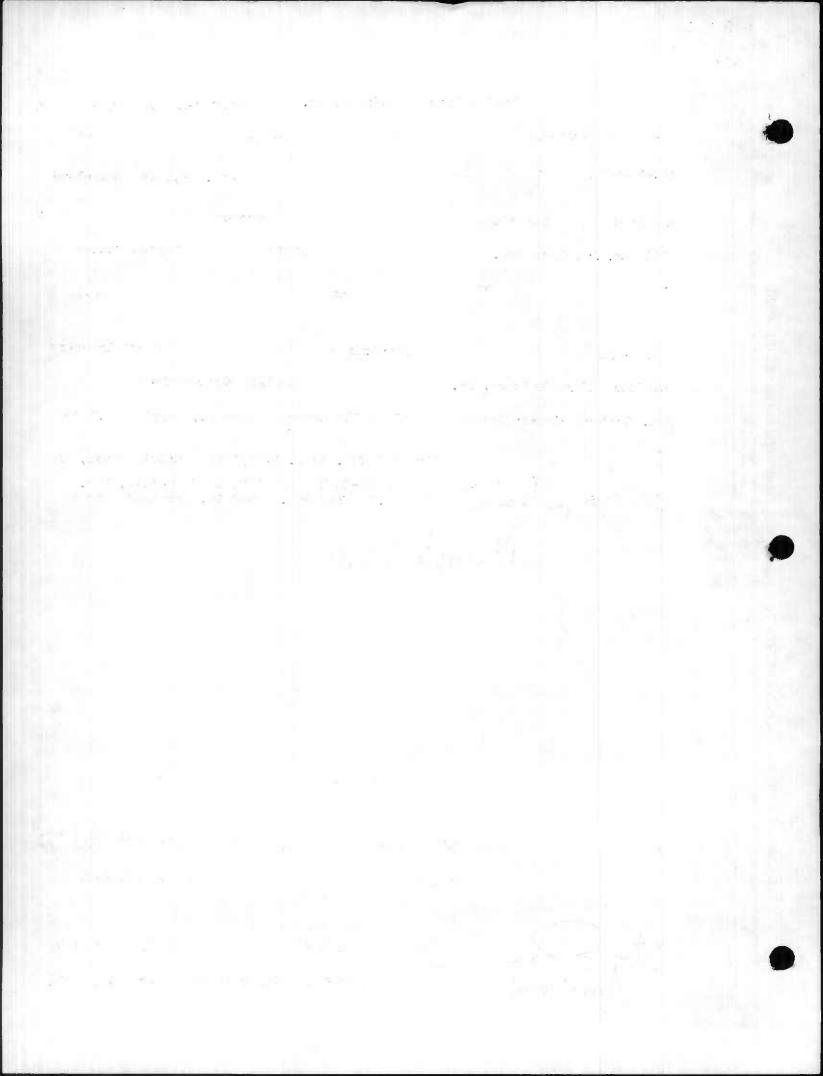
With Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E SEPTEMBER 20,1998 min who completed cause of death (Item 23a) (Type, Print)

State Registrar 30. Nar

31. Date filed (Month

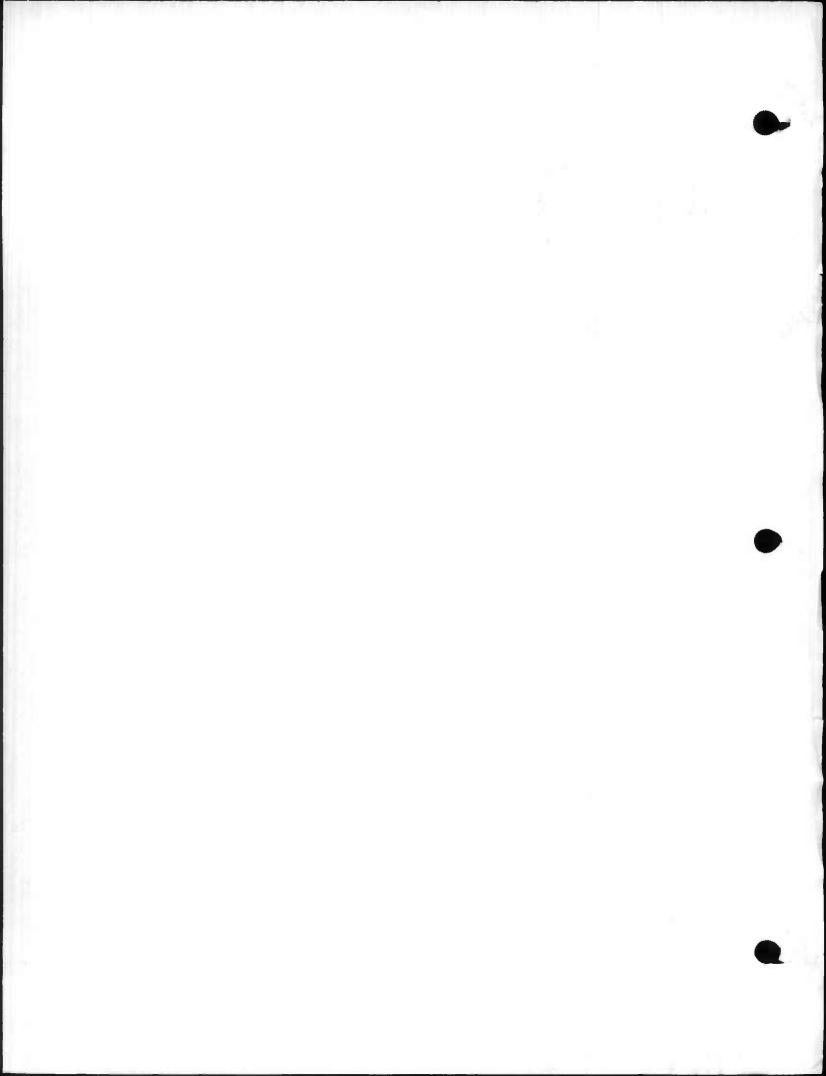
SEP 2 3 1998

32. Registrar's Signature



20 pm			pino	
5			1, 2, 3 sh	
Vera Krimmell 9/20198 5:20 Pm	BALTIMORE, MARYLAND 21215-0020	ments that the death certificate be executed within yours after death. Page 6 may be retained by the hospital or attending physician.	game by the amending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made an amendal hygiene prior to burial, cremation, or removal.	examiner must be notified at once.
2		nours aft	ely filled in by lation, or remo	, the medica
Y K	DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law mounts that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been asset by the mending physician and completely filled in by the fi be filed within 72 hours after death with the State Direct of hours and Mendal Arginere prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MAI		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.						
Į.	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	M=45	3. TIME OF DEATH				
- 4/4	VERA GLADYS KRIMMELL			SEPT. 20	1998	5.20 P M				
	4. SOCIAL SECURITY NUMBER 5. SEX 6.		UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	THPLACE (State or Foreign				
	212-30-7285	87 YRS. MO	NTHS DAYS HOURS MIN.	(Month, Dey, Year) 04/27/11	Cour	ntry)				
- 8	9e. FACILITY NAME (If not institution, give street end number)	98	CITY, TOWN OR LOCATION OF		9c. COUNTY OF	RYLAND DEATH				
TOR	GLEN MEADOW NURSING CENTER		GLEN ARM		BALT	IMORE				
DIRECTOR	10e. STATE 10b. COUNTY	10c. CITY, T	OWN OR LOCATION		10d. INSIDE CITY LIMITS?					
	MD BATTIMORE 10e. STREET AND NUMBER	GL	IN ARM		1 TES 2 NO					
FUNERAL	THE STILL POINT HOMBEN		101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?				
R	11630 CLEN ARM ROAD		21057		USA					
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yee or No— 14. RACE — Americal III. Naver Married 2. Married Process 1 Yes 2 No Hyes, specify Cuban, Mexican, Puerto Rican, stc.) 14. RACE — American Hyes, specify Cuban, Mexican, Puerto Rican, stc.)									
ВУ	1 Never Merried 2 Merried IF YES, GIVE WAR		1 YES 2 NO Spe		5.00	nc/fy:				
					W	HITE				
LED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEOENT'S USI (Give kind of work	done during most of working	16b. KIND OF BUSI	NESS/INDUSTRY					
LET	Elementery/Secondery (0-12) College (1-4 or 5+)	life. Do NOT use re	tired.)							
AP	12+4	SECRET	ARY	BOARD O	F EDUCA	TION				
COMPL	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S I	NAME (First, Middle, Maiden S	urname)					
ш	JOHN MOSER		3/5	ERA G. ARNOL	D					
0	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING AD	DRESS (Street and Number or Run							
2	= = >11=== > > > = 1				Siele, Elp Gode)					
	JOHN C. KRIMMELL		OX 434 SOMERS							
	20e. METHOD OF OISPOSITION 1	20b. PLACE AND DATE OF D		DATE 20c. LOCA	ATION — City or	Town, State				
		DUT ANEX VA	LEV MEM CAR	9/24 000	KEYSVIL	LE MD				
	21. BIGNATURE OF FUNERAL BERVICE LICENSEE	DODPENDE TIE	NAME AND ADDRESS OF	FACILITY	40	DE7 (1D				
	1/////		JOHNSON FUNE 8521 LOCH RA	VEN BLVD.	TOWSON	MD 21286				
NO	ahock, or heart failure. List only one cause immediate cause final disease or condition resulting in death) Sequentially list conditions,	on each ilna.	cardial i	-		Approximate interval Between Onset and Daath 3 hour 4 ears				
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	AS A CONSEQUENCE OF):								
	d									
MEDICAL	PART II. Other significant conditions contributing to det	ith but not resulting in t	ne underlying cause given	In Part I. 24a. WAS AN A PERFORM	MED?	Ib. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
Z										
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	To	28. PLACE OF DEATH (Check only one)						
YS!	1 YES 2 NO 1 Inpatient 2 ER	/Outpatient 3 DOA	Nursing Home 5 - Residence	e 8 Other (Specify)						
BY PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	URY 28b. TIME O		28d, DEŞCRIBE HOW IN.	JURY OCCURED					
	- Indiagni	JURY — At home, ferm, stree (Specify)	el, factory, office							
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beet of examiner.					r(e) and manner ee stated.				
BE	296. SIGNATURE AND TIME OF CERTIFIER	- Mil	29c, LICENSE N	UMBER 25205	29d. DATE SIGNE	ED (Month, Day, Year)				
T0	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF M. A. R. Ley G-BMC/	G 70 1	N. Choles	St. Bn	Cto.n	18 21201				
	31. DATE FILED (Month, Day, Year) SEP 2 3 1998 32. REGISTRAR'S	SIGNATURE 4	Sports							



Please Type or Print in Biack indelibie Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** September 20, 1998 Kouba 3:00A. M. Anna /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Rosedale Finder 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Franklin Square Hospital Baltimore enter If Under 1 Year Age (In yrs. last birthday) 93 Yrs. Birthplace (State or Foreign Country) **Funeral** Months Days 212-10-2412 1□M 2⊠F Director MD Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Insida City Limits MD Baltimore Rosedale 1 Yes No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8105 Old Philadelphia Rd. 21237 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Yas 25 No If Yes, Give Year or Dates: 1 Naver Marriad 2 Married 1 ☐ Yes 2 No Specify: white Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Be Anna M. Petrlik Joseph J. Valis 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1914 Wilson Point Rd. Baltimore, MD 21220 Josephine Valis/sister Itam 27 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, Stata 20a. Method of Disposition Most Holy Redeemer Burial 2 Cremation 3 Removal from State 5 Other (Specify) 9-22-98 Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical · Hypoxemia Examiner Dua to (or as a consequence of): Examiner 19 Hours strointestina Hemmorrhage physician and s the bunal-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by Heart Failure 3 ☐ Probably 4 Unknown 1 Yee 2 No Longestive þ 24b. Were autopsy findings available prior to completion of ceuse of daath? Completed 24a. Was an autopsy Peripheral Vascular Disease 1 ☐ Yes 2 ☐ No certificate 25. Was cese rafarred to medical axaminar? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation To the Hespital or Attending within 24 hours after death.
To the Funeral Director: After completaly filled in by the fun 1 Yes 3 Sulcida 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

September 21,1998

9000 Franklin Square Drive Baltimore, Manyland 21237

State Registrar 30. Name and add

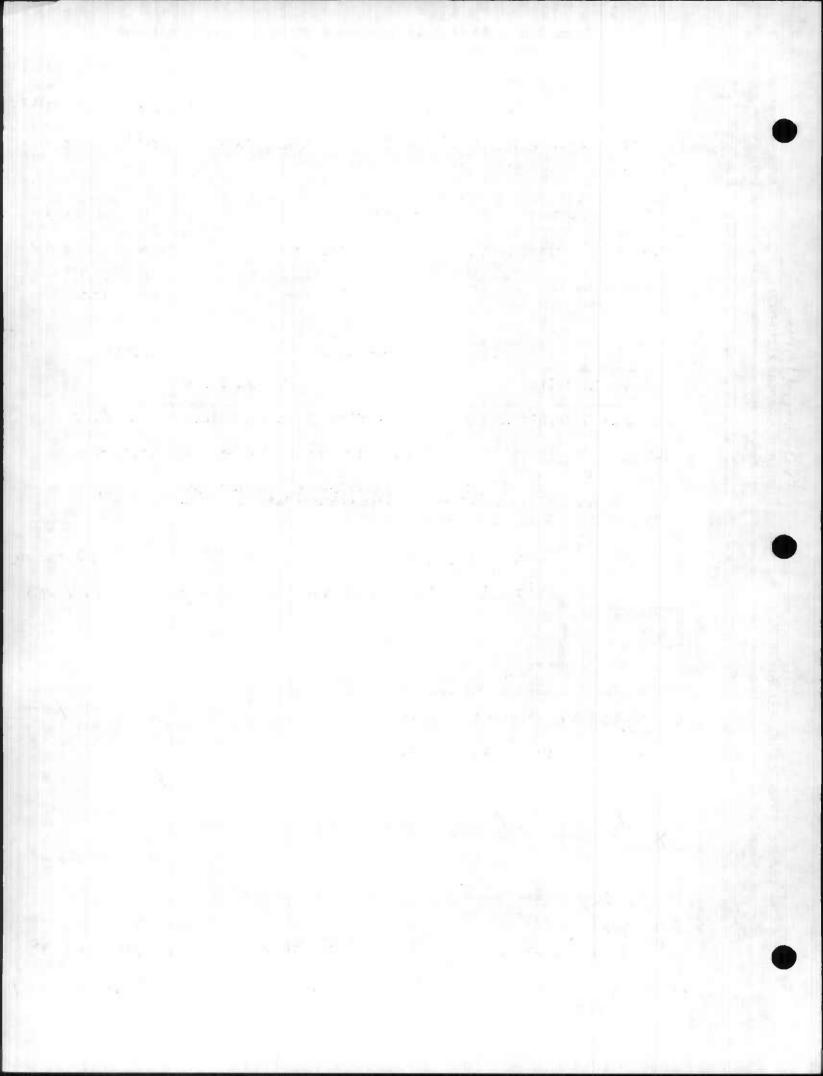
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ess of person who completed ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

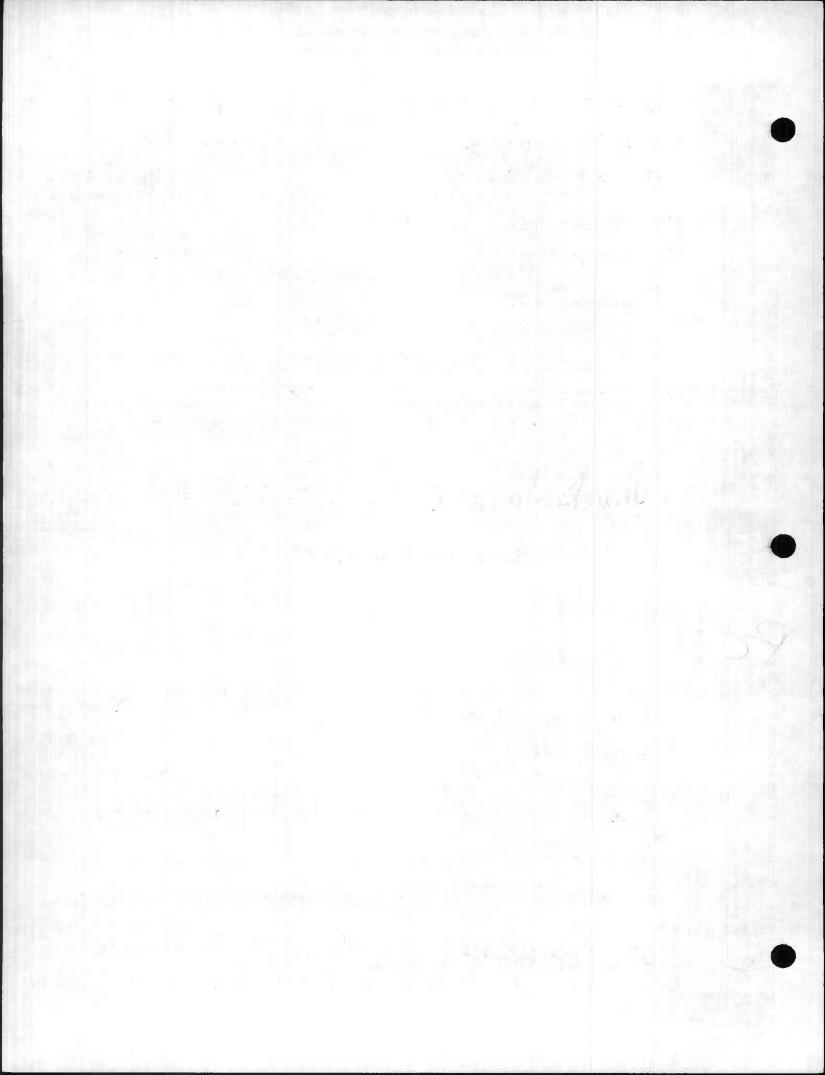
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Day **Physician** Klinedinst 8:30Pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore battimore Count Wilkens Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign
 Country) **Funeral** 1 M - 2 F 68 Yrs. Director 215-24-8379 Nov. 4,1929 Maryland Usual Residence of Deceden filed within 72 hours efter deeth with the Meryland Hygiene. Hygiene "naturs!", or Herne 23a or 28a-f show ent, ins lead of Example must be notified a 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County 1 ☐ Yes 2 ☑ No Maryland Baltimore Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4307 Wilkens Avenue 21229 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify P 3 ☐ Widowed 4 ☒ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Own Home 7 is marked other trsumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 end 2 should be Alvin Webster Rita Tankersly 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) Health em 27 is RD #2 Pine Tree Road Spring Grove, PA 17362 Charles M. Cook, son : If item 27 or other t 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1X Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Loudon Park cemetery 9/23/98Baltimore, Maryland 22. Name end Address of Facility 21. Signature of Funeral Sa Ambrose Funeral Home, Inc. Arbutus 1328 Sulphur Spring Road Maryland 21227 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Ceuse (Finel Esophagea cance disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 88760 4 to Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Unknown 1 Yes 2 No artery disease à 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed laryngeal cancer is certificate has by director, page 2 s The 1□ Yes 2 No 1 TYPE 2 NO or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1□ Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Naturel 5 Pending death. 1 Yes 2 No 2 Accident investigation after death 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier and address of person who co use of deeth (Item 23a) (Type, Print) Street Battimore, Maryland 21201 Rudikoff South Ento Bari 16 31. Date filed (Month, Day, Year) SEP 2 3 1998 32. Registrar's Signature Registrar



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Division of Vital Records.

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State Registrar

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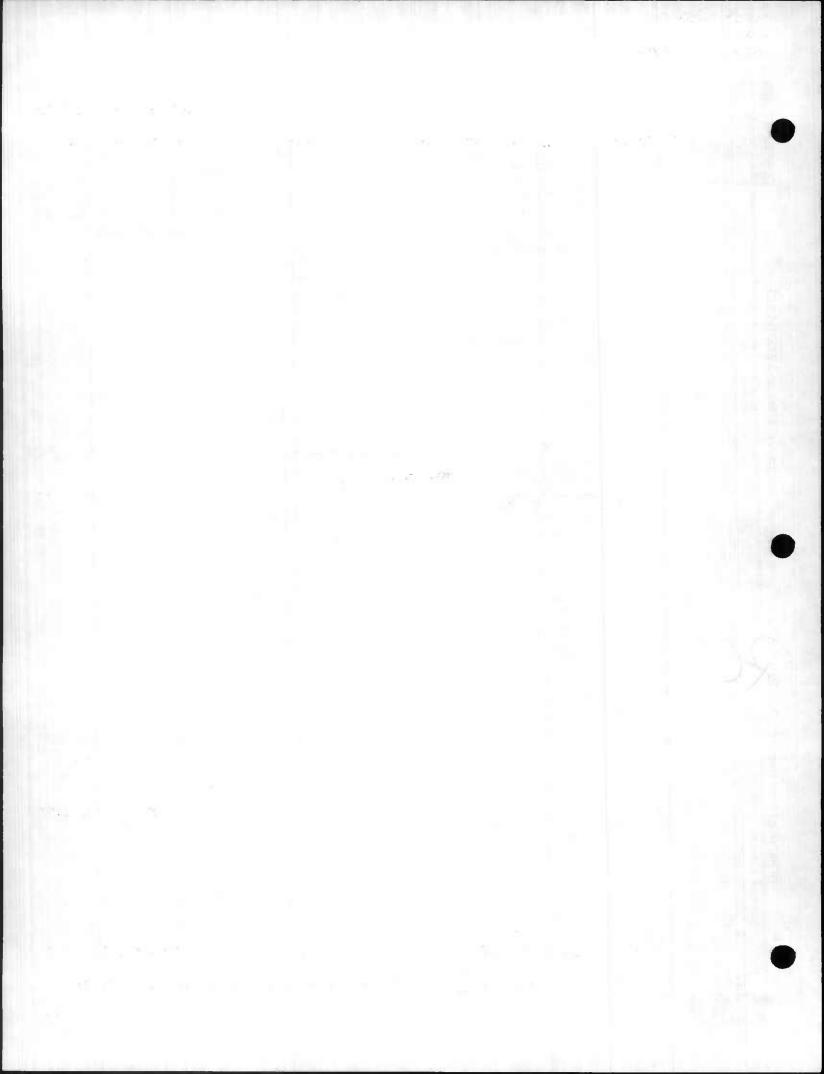
m 32 Registrar's Signatura Spera

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

29d. Date signed (Month, Day, Year)

SEPTEMBER 14, 1998

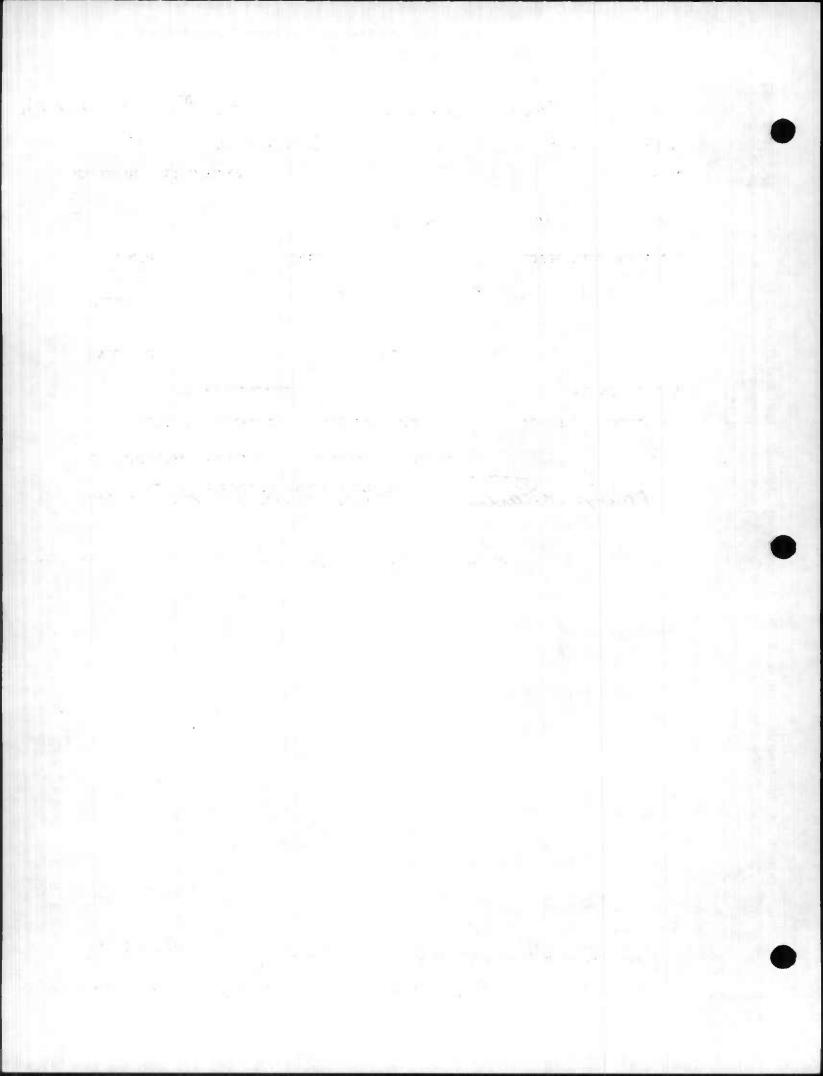


State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	4a Facility Nama of not institution, g		2027, 2	510		4b. City, Town, or	Location of Death	4c. County	of Death			
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and selth	THE SISTERS OF M	ERCY	P	.O. I	30X 114	48 BALT	IMORE, MI	21202				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** -26/Am ERMAN ee September 21, 1998 ation of Daeth 4c. County of Deeth /Medical 4a. Facility Nama (If not Institution, giva straat and number) 4b. City, Town, or Location of Daeth Examiner Ritchie 7. Aga (In yrs. last birthday) Ba Ho Joseph 5. Social Sacurity Number If Undar 1 Year | If Undar 24 Hrs. 6 Sax 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Min. 1₩ 2□ F 72 Yrs. Director 218-12-4407 19, 1926 MD Usual Rasidanca of Dacadant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 28a-f show the Medical Examiner mant be notified at Director TYPY'as 2□No MD N/A 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 9 3939 ROLAND AVE 23a 21211 Funerai death U.S.A. Homes 1 12. Was Decedant Evar in U,S. Armad Forces? 1 XYas 2 No If Yes, Give Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Rece - American Indian, Black, Whita, etc. 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 ò 1 Yas 2 No Specify: by Specify: BLACK 3 Widowad 4 Divorced "natural", Completed 15. Dacedent's Education (Spacify only highast grada complated) 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratirad) 16b. Kind of Businass/Industry permit. Pages 1 end 2 should be filed within Depertment of Health and Mental Hygiene. Important: if item 27 is merked other than any Injury or other trainment. Elamantary/Secondary (0-12) College (1-4or 5+) HOSPITAL HISTOPATHOLGY 2yrs TECH 12th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) JOHN LEE OZERBELL HARRIS 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) TOREA LEE 2702 E. HOFFMAN ST BALTO MD 21213 20b. Placa of Disposition (Nema of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burlal 2 ☐ Crametion 3 ☐ Ramoval from Stata 9-25-98 BALTO, MD 5 ☐ Othar (Specify) Arbutus Mem pk 22. Nama and Addrass of Facility BETTS FUNERAL HOME 21. Signature of Funeral Service Licansea 1129 N. CAROLINE ST BALTO, MD 21213 23a. Part 1. Entar the disease, or complications that ceused the death. Do not entar the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximata Intervel Batwaan Onsat and Death **Physician** /Medical Immediata Cause (Finel (arrenoma disease or condition rasulting in death) **Examiner** Examiner 0 Saquantielly list conditions, if any, laeding to immadiata causa. Entar Underlying Causa (Disaasa or Injury that Initieted events resulting in daath) Last end Dua to (or as a consequence of) be execu Records, P.O. Box 68760, physician Physician/Medical the Dua to (or as a consequence of): 98 ettending for Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part i. 23b. Did tobacco usa contribute to the cause of death? by the 1 Yes 2 No 3 Probably 4 Unknown b 8 24b. Were autopsy findings eveilabla prior to complation of ceuse of death? Completed 24a. Was en eutopsy 1 Yas 2 No 1 Yes 2 No certificate Division of Vital Be 25. Was cese rafarred to medical axaminar? 26. Place of Death (Chack only ona) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice P 1 Yas 2 No 1 inpatient 2 ER/Outpatiant 3 DOA After this 27. Mannar of Death 28a. Data of Injury (Month, Day Yaar) 28b. Tima of 28c. Injury at Work? 26d. Dascribe how Injury occurred Medical Certification: or Attending P 5 Panding investigation 1 Natural 1 ☐ Yes 2 No 2 Accidant Director: 6 ☐ Could not be datarmined 3 ☐ Suicida 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stata) 4 Homlcide 10 Certifying Physicien: To the best of my knowledga, deeth occurred at tha time, dete end plece, end due to tha causa(s) and menner es steted.
2 Medical Examiner: On tha besis of examinetion end/or invastigation, in my opinion, daeth occurred at tha time, dete and plece, end due to the causa(s) end mannar stated. 29a. Cartifian (Check only one)

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29b. Signature and title of confi

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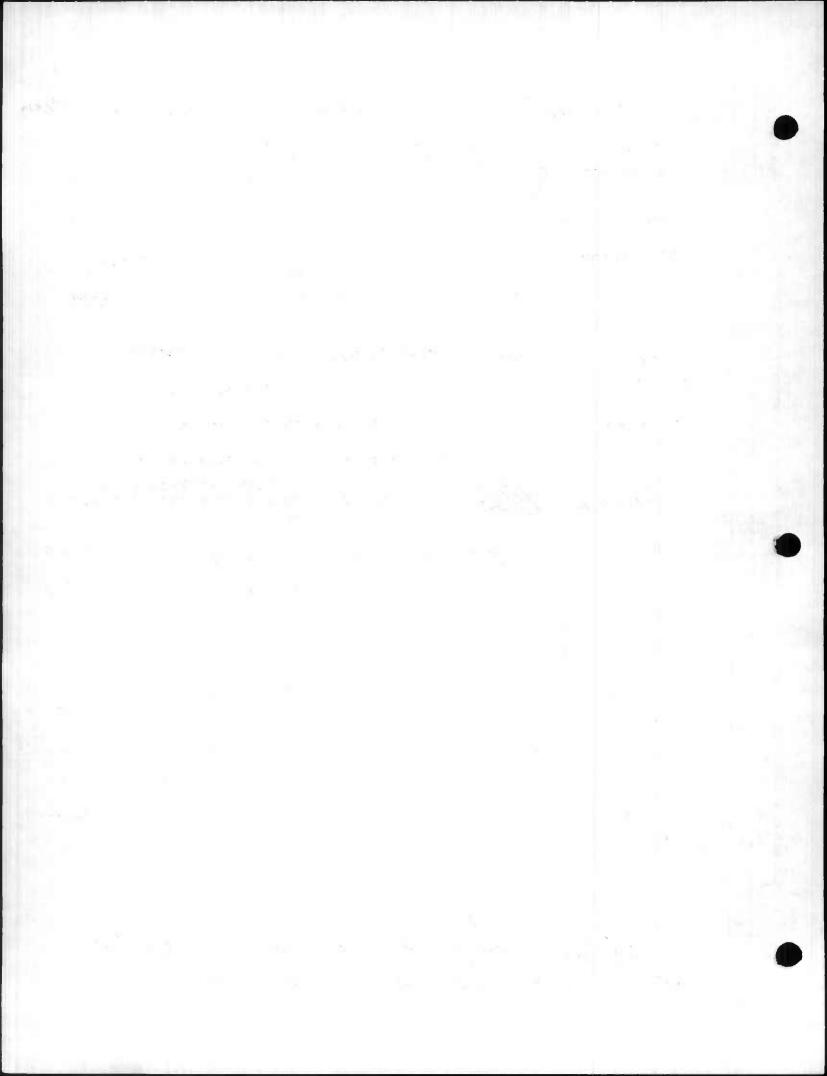
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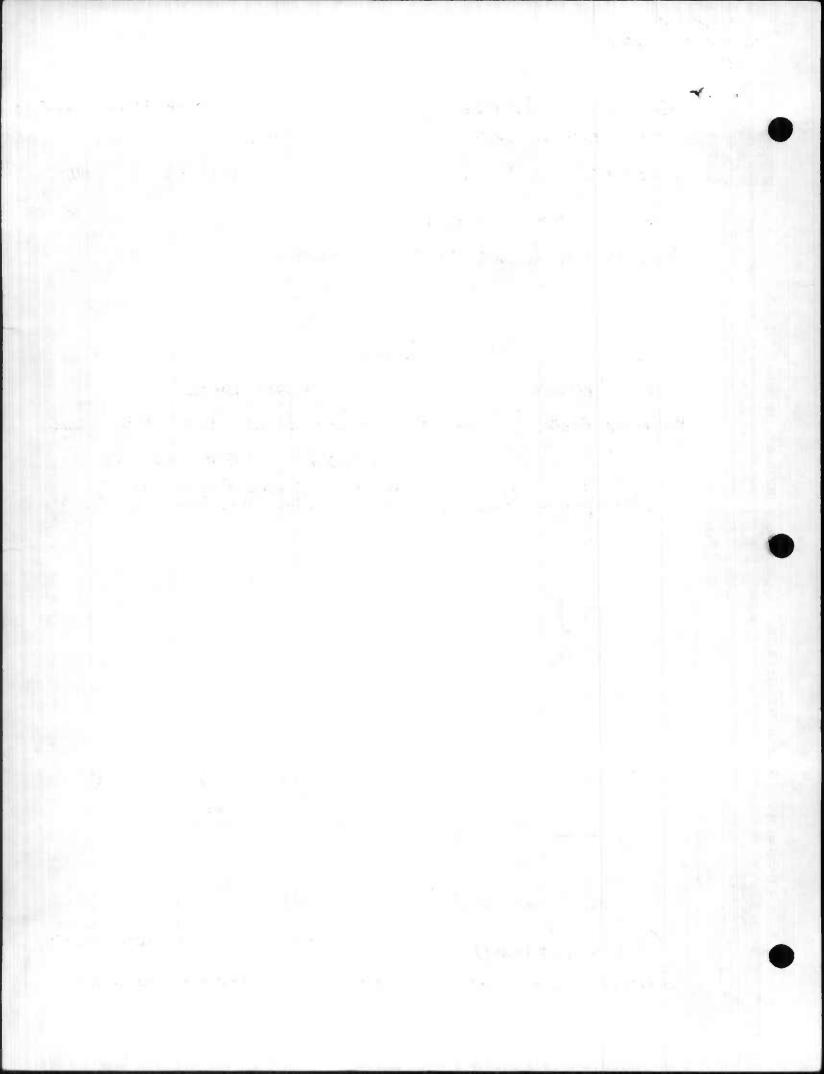
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29d. Data signed (Month, Day, Year)



DHMH 16 Rev 6/95

98-5400-510



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Daeth 3. Time of Death Day **Physician** 55 ERONICA /Medical 4a Fecility or Location of Daath 4c. County/of/Death **Examiner** last birthday) If Under Yaar Data of Birth (Month, Day 9. Birthplaca (Stata or Foreign **Funeral** Deys Months Hours 1 □ M 2 🗹 F Director 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be nothing at 1 PYas 2 No Director 10e. Street and Number 10f, 10g. Citizan of What Country? Funeral 12. Was Decadant Evar in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indien, Black, White, atc hours efter 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) permit. Pages 1 end 2 should be filed within 72 P. Depertment of Heelth and Mental Hygiene. Important: If Item 27 is merked other than "natuany Injury or other traumatic event, Item Mentals." 15. Dacedant's Education (Spacify only highast grade complated) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) Collega (1-4or 5+) YE 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Be 2 19b. Majling Addresa (Straat and Number or Rural Route Number, City or Town, 9e. Informant's Neme/Ralationship (Type, Print) Stata, Zip Coda) mother 20a. Mathod of Disposition 1 Burial 2 Gamation 3 Ramoval from Stata 4 Donation /5 Othar (Specify) 21. Signature of Fanaral Service Licen indications that caused the death. Do not anter the mode of dying, such as cardiec or respiretory errast, one cause on each line. Approximata Intervel Batween Onsat and Death Physician Immadiata Ceuse (Final disaase or condition rasulting in daath) /Medical 2 Head Examiner Physician/Medical Examiner 6-12 Kees Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Diseasa or Injury Box 68760 that initieted avents reaulting in death) Last Dua to (or as e consaguance of) to Division of Vital Records, P.O. Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown by Completed 24b. Wara autopsy findings evailable prior to page 2 should 24a. Wes an autopsy performed? peeu completion of causa of daath? The lew this certificate has 28 NO 1 ☐ Yes 2 SNo 1 🗆 Yas To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was casa raferred to madical axaminar? 26. Pleca of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Dothar (Specify) Hosfield 1 Yas 2 No Medical Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding investigation 1 Maturel 2 Accidant 6 Could not be 3 Suicida 28a. Place of Injury - At home, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledga, daeth occurred at tha tima, date end place, and due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the basis of axemination and/or invastigetion, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and manner platad. 29a. Cartifiar (Check only one) 29b. Signatura and title of certify 29c. Licansa number 29d. Date signed (Month, Day, Year) 02290

f deeth (Itam 23a) (Type, Print)

827

Registrar's Signatura

32.

KTIMORE, MD,

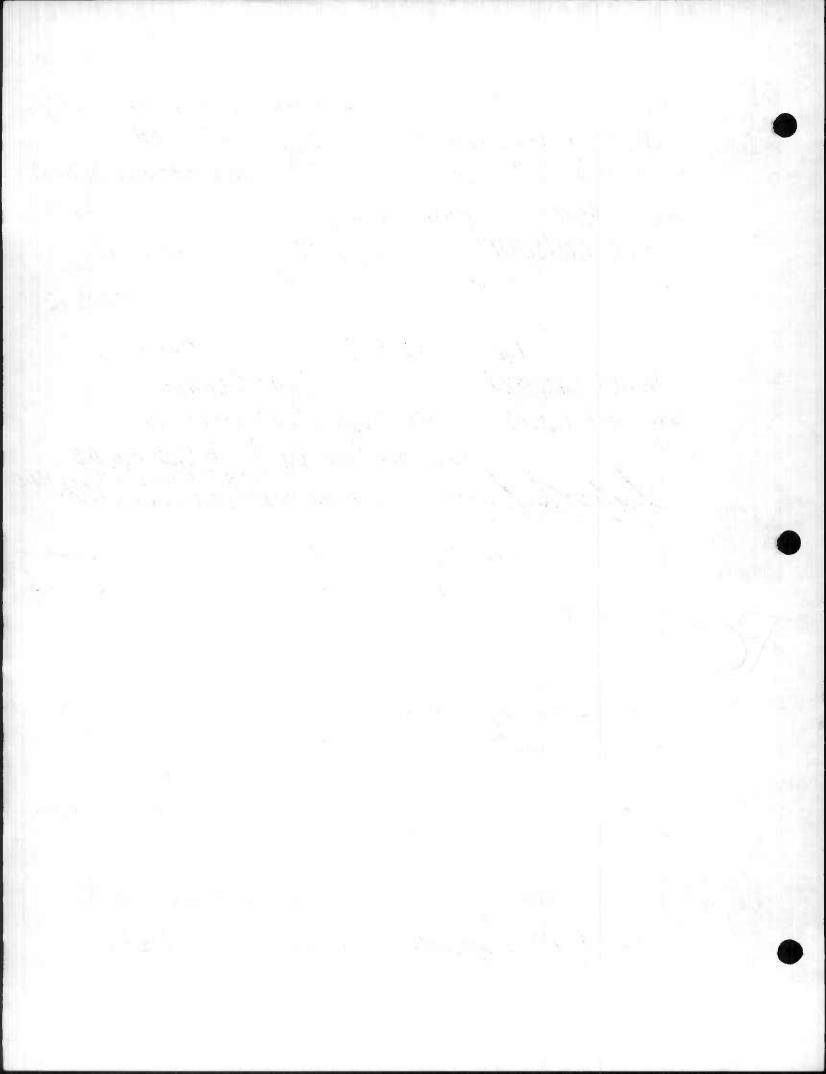
State Registrar cepall

G. HAYE

SEP 2 3 1998

30. Name end adorass of pe

31. Data filad (Month, Day, Yaar)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death **Physician** EMMA MARIE MICHAEL /Medical Feejlity Nama (It not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PC was 6. Sex If Under If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days 1□ M 2 F Hours Director 219-28-4681 NOV 23,1920 MARYLAND Usual Residence of Decedent 10a. Stata 10b. County 10d. Inside City Limits 10c. City, Town or Location CATONSVILLE 1 Yas 2 No Director BALTIMORE 28e-f MARYLAND 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8 U.S.A. 21228 98 SMITHWOOD AVENUE 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, Whita, atc. 1 ☐ Yas 2 ☐ No 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 b 1 Yes X No Specify: þ 3 Widowed 4 □ Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Hygiena. filed within Elementery/Secondary (0-12) College (1-4or 5+) INSURANCE COMPANY INSURANCE SUPERVISOR 12TH GRADE 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middla, Last) Pages 1 and 2 should be fill trient of Health and Mental Hi tant: If them 27 is marked oth jury or other traumatic evens Be ROSE BASS SAMUEL HAINES 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 200 N. BEECHWOOD AVENUE-APT-C-BALTIMORE, MARYLAND FRANCES RODERICK (DAUGHTER) 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stete 20e. Mathod of Disposition 9/23/98 Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata
4 ☐ Donation 5 ☐ Othar (Specify) MEADOWRIDGE MEMORIAL PARK ELKRIDGE, MD 22. Nama and Address of Facility 21. Signatura of Funeral Sarvice Licenses HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 23a. Part1. Enter #e disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haert failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in daath) neumonia Examiner Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last for as a consequence of Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 40 Unknown 1 Yes 2 No 3 Probably à 24a. Was an autopsy performed? 24b. Wera autopsy tindings available prior to Completed completion of cause of death? 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 1 Matural 2 Accident 28c. Injury at 28d. Describe how injury occurred 5 Panding invastigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide edical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar as steled.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steled. 29e. Certifier (Check only 3 one) Fo the Š 29b. Signature and title of certifier 29c. License numbe 29d. Data signed (Month, Day, Year) 30-Nama and addrass of person who completed causa of death (In na 23a) (Type, Print

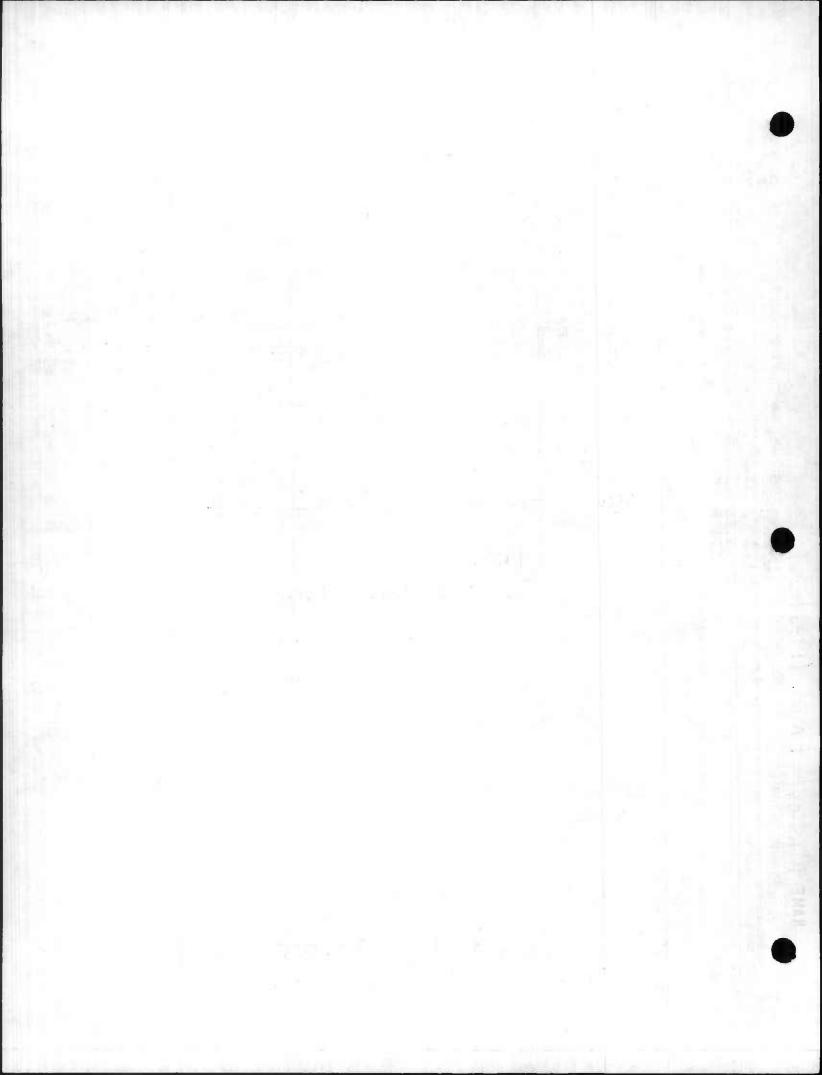
State Registrar

Data filed (Month, Day, Year) SEP 23

1998

Emme

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 98 298

			Cei	rtificate of	f Death		Reg	. No.	t to	210	, ,
1. Decedent's Name (First, Mi	2.	Date of Death Month	Day	Year	3. Time of	Death					
MURRILL JOSE	PH MURRAY,	SR.				SI	EPTEMBE	R 20,1		6:30	A.M.
4a Facility Name (If not institu	tion, give street and num	nber)			4b. City, To	wn, or Locati	on of Death	4c. County	of Death		
CHESAPEAKE H	EALTH CARE				ARNO	OLD		ANNE	ARUNI	DEL	
5. Social Security Number		7. Age (In yrs. le		If Under 1 Yea Months Day		24 Hrs. 8.	Date of Birth (Month, Day, Y	ear)	9. Birthplac	e (Stete d	r Foreign
213-05-3045	15₹M 2□ F	83	Yrs.			Al	PRIL 13	,1915	BALT		
Usual Residence of Decedent 10a. State 10b. Cou	nhv	10c City	Town or Lo	cation					104	l. Inside Ci	ity I Imite
1000		Too. Only,							100	1 🗆 Yes	
	E ARUNDEL		PA	SADENA			1.0	0.00			-X
10e. Street and Number				10f. Zip Code			100	. Citizen of V	vnat Country	7	
8063 CATHERIN		4 - 15 - 110	40.1	- PO 46	122	I-1-0 (01h		U.S.A.	e - American	Indian	
1. Marital Status	Armed For		13.	Was Decedent of If Yes, specify Cu	iban, Mexicar	n, Puerto Rici	an, etc.)		k, White, etc		
1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☑ Divord	if Yes Give	0		1□Yes 2DXN	o Specify:			Specify	WHI	ΓE	
	dent's Education	,100.	16e Decer	dent's Usual Occ	upation		16	b. Kind of Bu	isiness/Indus	stry	
(Specify only hig	hest grade completed)	4-10-1	(Give	kind of work don DO NOT use retii	e during mos	at of working					
Elementary/Secondary (0-1: 9TH GRADE	2) College (1-	-40r 5+)	PO	LICEMAN			R	ALTIMO	RE CIT	ry	
17. Father's Name (First, Midd	le, Last)		10	CT OFFIUM	18. Mothe	er's Name (F	irst, Middle, Me			Pr. de	
FRANK A. MURR	AY.SR.				CATE	HERINE	RIPKEN				
19a. Informant's Name/Relation			19b. Mailir	ng Address (Stre				City or Town.	Stete, Zip C	ode)	
JUNE M. SCHWA		2)		APPLESE						1.412	
20a. Method of Disposition	KIE (DIDIEK	20b. Pla	aca of Dispo	sition (Name of				c. Location -		n, State	
1 X Burlal 2 ☐ Crematic		State		ARK CEME		9/2	3/98	BALTIM	ORE		
4 Donation 5 Other 21. Signature of Funesal Servi		1200		2. Name and Add			37 30	2112 - 211	OIL		
Vackie,	W. Sha	mor	_	UBBARD F 107 WILK				DE MA	DVIAM	0 215	23
23a Pany Enter the disease	, or complications that ca	aused the death.							A	pproximat	e
nock, or heart failure. L	ist only one cause on ea	ach line.							C	nterval Bet Inset and i	Death
Immediate Cause (Finei	4.0	0	6	cilar	0				m	no m	onth
disease or condition resulting in death)	a. / U	Due to (or	as a consec	mance of):					1	01.1	00110
	ob	struc			ropo	+1			‡		
Sequentially list conditions	b		as a consec		· Ope	x · M	7				
if any, leading to immediate cause. Enter Underlying	00	luic		-200							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6.	Due to (or a	as a conseq	uence of):							
resulting in death) Last	1,001		car	_					i		
	d	On	COIP,	VE I					1		
Part II. Other significant cond	litions contributing to de-	ath but not result	ting in the u	nderlying cause (given in Part I	1.	23b. Did tob	acco usa cor	ntribute to ti	he cause	of death?
	10 -						1 🗆 Yes	1	3 Proba		Unknown
prosta	IT CON	LEV									
domanat	0	- 1/6 1	-	100	1:50		24e. Wes en		24b. Were	eutopsy able prior	findings
www	12, 100	avely	150	7750	U 260	we	periorite	, or	comp of de	pietion of a	ause
dia 1-0-	405						1□ Yes	2 No	10		No
25. Was case referred to med	ical				26 Place	e of Death /	theck only one)	7			
examiner?	Hospital:	npatient 2 E	R/Outpatler	nt 3 DOA	Whore . A		5 ☐ Residen	ra & COM	er (Speciful		
27. Menner of Death			28b. Time of	1			. Describe how				
1 Netural 5 Pen 2 Accident inve	ding (Month	n, Dey Year)	Injury		?ork? □Yes 2□						
3 ☐ Sulcide 6 ☐ Cou	aid not be 28e. Place	of Injury - At hon	ne, farm, str	eet, factory, offic	a	28f.	Location (Stre		er or Rural F	Route Nun	nber,
4 Homicide	buildin	ng, etc. (Specify)	, , , , ,	7,			City or Town,				
29a. Certifier 1 Certif	ying Physician: To the t	best of my know	ledge, death	n occurred at the	time, date an	nd place, and	due to the cau	se(s) and me	enner as stat	ed.	
(Check only 2 Medic	cal Examiner: On the be-	sls of examination	on end/or in	vestigation, in my	opinion, dea	ath occurred	at the time, date	e and pleca,	and due to the	ne cause(3)
29b. Signature and title of cart				29c. Lice	nse number		290	d. Date signe	d (Month, De	ay, Year)	
1	ne	15	2		7410	4 1-		9-	21-	95	1
20 Namo and addition of	an who are stated to	of death (train	22a) /T	Deline)	11	112		- (10	
30. Neme and address of pers	wno completed cause	A A	23a) (Type,	(CT/ 4	201	Ro.	1d +	Aria 1	14	0	2/01
31 Date filed (Month Day Vo	arl do B	egistrer's Signatu	159	Jone J.	1	100		17 710 /	el //	V -	1016
31. Date filed (Month, Day, Ye	000	Solding o Oldingto	160 .	whowen							

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DIVISION OF VITAL RECORDS, PO BOX 68760 BALTIMORE, MARYLAND 21215-0020

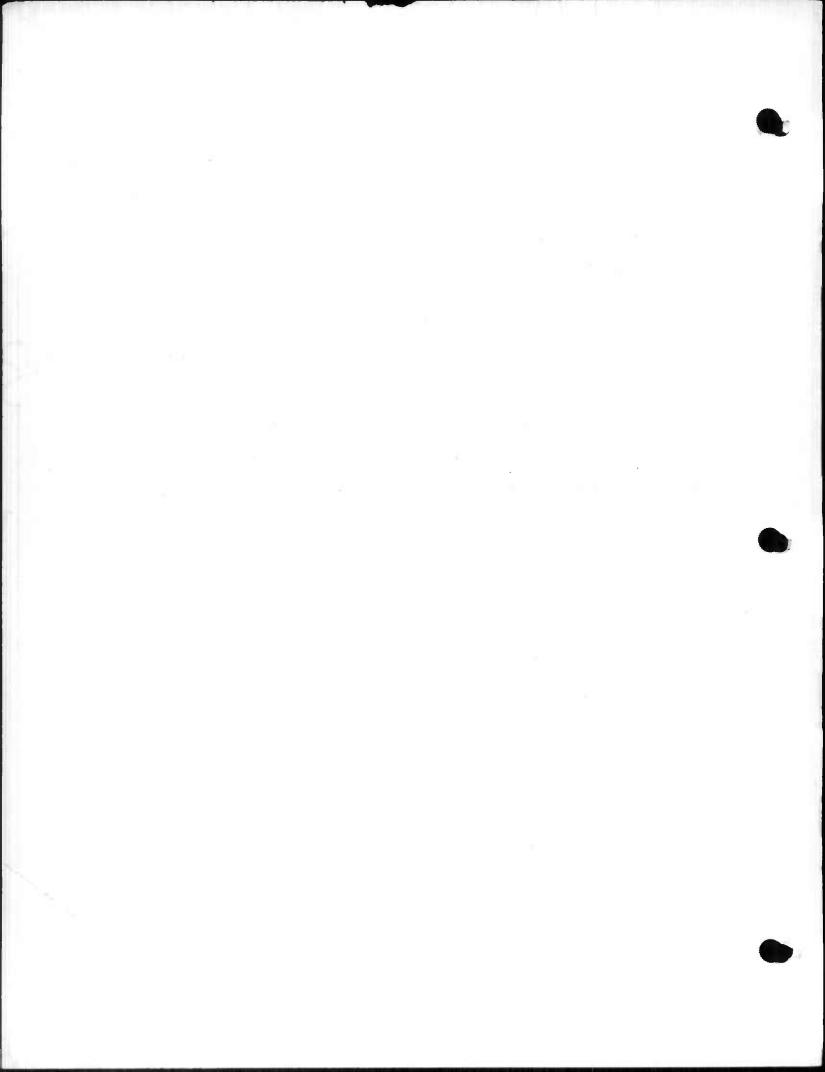
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the dean removes the executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the same for the properties of

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICALE O	F DEATH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Lest)	- No	NINI			2. DATE OF DEATN		3. TIME OF DEATN
	I HNN E C	GLE II	MININ			September		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH		IRTHPLACE (State or Foreign
	212 22 22	1 M 2 F F		MONTHS DAY		(Month, Day, Year)	Cc	ountry)
	212-22-3858 9e. FACILITY NAME (If not institution, give stre		84 YHS.	01 000 000		May 19, 19		Md.
oc		sec and number)			N OR LOCATION OF D	EATH	9c. COUNTY O	IF DEATH
ᅙ	Wesley Home			Balt.	imore		N/A	A
DIRECTOR	10e. STATE 10b. COUNTY		too CIT	Y, TOWN OR LO	CATION			
<u>E</u>				200 200				10d. INSIDE CITY LIMITS?
	Md. N/	/A	B	altimo				1 YES 2 NO
¥	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?
当	5923 Leith Walk				21239		USA	A
FUNERAL		12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS E	ECENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No- 14. R	tACE — American Indian, Black, White, atc.
BY F	1 Never Married 2 Married	IF YES, GIVE WAR OR			ES 2 NO Specific	an, Puerto Rican, etc.)		Reck, White, atc.
	3 Wildowed 4 Divorced		<i>p</i>			,	"	White
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION	18. DECEDENT'S	USUAL OCCUP	TION	16b. KIND OF BUS	INESS/INDUSTR	IY .
	Elementary/Secondery (0-12)	College (1-4 or 5+)	life. Do NOT us	vork done during se retired.)	most of working			
릴	12		Secreta	rv		Boys La	tin Sch	0001
8	17. FATHER'S NAME (First, Middle, Lest)		Decrees	/	16 MOTHER'S N	ME (First, Middle, Malden		1001
	Hampton	C	1 .				Surneme)	**
BE	19e. INFORMANT'S NAME (Type/Print)	50	eele	ADDRESS (Ot	Katheri			Horsey
2						Route Number, City or Town		
	Mrs. Paula A. Henr					Baltimore,		
	1 M Burlel 2 ☐ Cremetion 3 ☐ Remov	ral from State Car	b. PLACE AND DATE	ther place!	*		CATION — City or	
1	4 Donation 5 Other (Specify)		reénmount				Baltimon	re, Md.
ľ	21. SIGNATURE OF EUNERAL SERVICE LICE	the W		22. NAME	AND ADDRESS OF FA	Funeral Ho	mo Inc	3
	1 stock	THE WAY	-			. Towson, A		
	23. PART I. Enter the diseases, Dr cD	molicetions that cause	d the death. Do c					
- 1	shock, or heart fellure. Li	at Dnly Dne ceuse Dn	ech ilne.	or oritor the t	mode of dying, suc	in all cardiac or reapi	raibry arreat,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition	nth. C	- /	A	2 1/-			Onset and Death
ı,	resulting in death)	Attno So	-anotic	leve +	so vasa	elen De Ja	ase	
		DUE TO (OR AS	A CONSEQUENCE OF	7):		•		
Z I	Sequentially list conditions, 6.							
Ĕ	If any, leading to Immediate	DUE TO (OR AS	A CONSEQUENCE OF	ን:				
CERTIFICATION	CAUSE (Disease or Injury							
는 II	that initiated events resulting in death) LAST	DUE TO (DR AS	A CONSEQUENCE OF	7:				
# 1	d.							
	PART II. Other aignificent conditions	contributing to death i	nut met engulting l	m Abialian da da				
EDICAL								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	Senile Den	erta, CM	ue ocst.	whe	Juliane	2 1 _ YES 2	NO	OF DEATH?
¥	- Tiseene				/		1	1 YES 2 NO
	DID TOBACCO USE CONTRI	BUTE TO CAUSE C	OF DEATH YE	S I NO	☐ UNCERTAI	N X		
× I	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT					
PHYSICIAN:		HOSPITAL:	patient 3 DOA	OTHER:	ome 5 Residence	8 C Other (Specify)		
₹	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIM		NJURY AT	28d. DESCRIBE NOW II	LIURY OCCURED	
	1 Netural 5 Pending	(Month, Day, Year)		URY	WORK? YES 2 NO	ava. Degarribe Non II	OUNT OCCURED	
B	2 Accident Investigation	28e. PLACE OF INJURY	/ _ At home from a					
	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Spe	city)	treat, tactory, or	nce	281. LOCATION (Street e City or Town, State)	nd Number or Flur	al Route Number,
ᇤ								
립	29e. CERTIFIER (Check only	AN: To the best of my know	rledge, death occurre	d at the time, d	nte end place, end due	to the cause(e) end man	ner ee stated,	
COMPLET	one) 2 MEDICAL EXAMINER:	On the basie of examination	n and/or investigation	n, In my opinion	, death occured at the	time, date end place, and	due to the caus	∍e(s) end manner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			
R	P-fal.	ATALA			D ?		DATE SIGN	NED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATN (ITEM 27) /5	Orine)	Vd1	×64	7/(0/186
	D. O.C O 1			r may	04.5	1 1 -	1	
	31. DATE FILED (Month, Day, Year)		BANK	5/	BACTO.	Mel 2120	14	
		32. REGISTRAR'S SIGN	ATURE	1	,		,	
	SEP 2 3 1998	June	10. p	parks				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day September 21, 1998 **Physician** 3:50 pm Kopert Mariner /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Mary and Hospital Bultimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 25 1931 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1KJM 2□ F 213-28-0965 66 Director Baltimore, MD Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23s or 28s-f show very fujury or other traumatic event, the Marical Emerican market periodical and page. 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Directo Maryland Anne Arundel Pasadena 10a. Street and Number 10f. Zio Code 10g. Citizen of What Country? Funeral 608 McMagan Drive 21122 USA 14. Race - American Indian, 12. Wes Decedent Ever in U,S.
Amed Forces?
1 \(\tilde{\text{DY}} \) yes 2 \(\tilde{\text{NO}} \) No
14 Yas, Give
Yeer or Dates: \(\tilde{\text{A1}} \) \(\tilde{\text{F0}} \) \(\tilde{\text{CC}} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 White 1 Yes 2 No Specify: Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) 12 College (1-4or 5+) Sales Manager +4 Industrial 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert D. Mariner Sr Marian Waters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informent's Neme/Reletionship (Type, Print) Robert D. Mariner 402 Dutchship Road Pasadena Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 9/22/98 | Baltimore MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena Md 21122 not enter the mode of dying, such as cardiac or respiratory arrest. LICHE 23e. Pert . Entar the disaase, of complications that caused the deal shock, or haert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceusa (Final cerebral hemorrhage disease or condition resulting in death) Examiner /pertension Sequentielly list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Disaese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Due to (or as a consequence of): Box Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Ryobably 4 Unknown cerebrovascular accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yas 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Minpatient 2 ER/Outpatient 3 DOA 2 28a. Data of tnjury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Athar Naturel Attending 5 Pending death. 1 Yes 2 No investigetion e Hospital or Attendi n 24 hours after death e Funeral Director. 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only To the P 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 29c. License number September 21, 1998 HODGSON, MD P10228 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

Denice Hodgson University of Mary and Hospital Bultimore, Maryland 21201

31. Deta filled (Month, Day, Year)

32. Registrar's Signatura

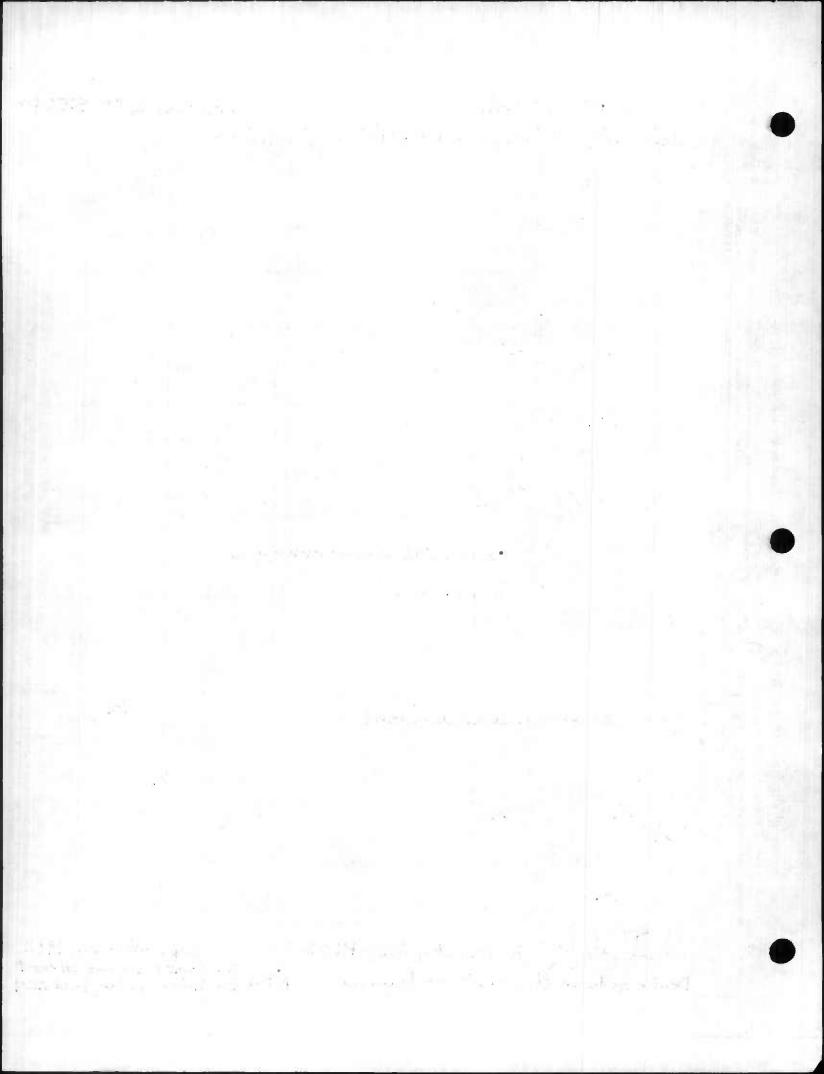
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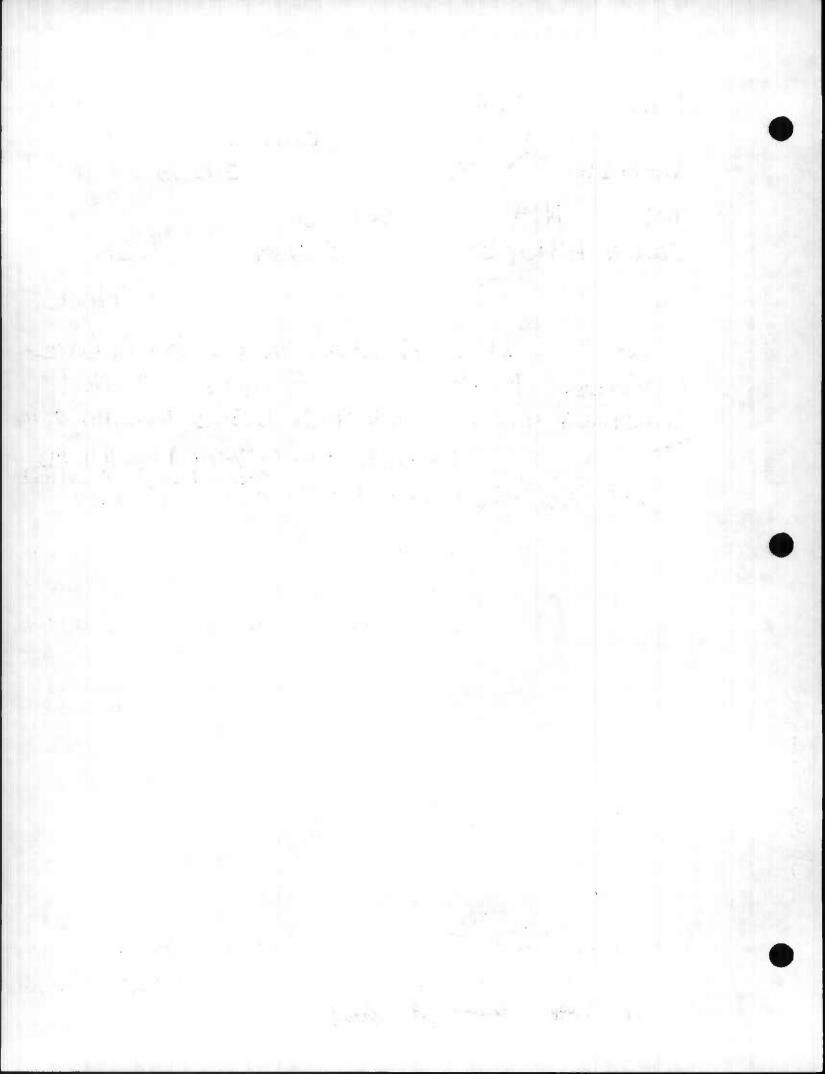


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** rickae 5:15 PN 98 1019 30 tember /Medical 4a Facility Name (If not institution, give straet end number) City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospita 21timore 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) 5 Social Security Number 219-20-6215 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 280 F Director Usual Residence of Decedent death with the Marylend 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, tre Medical Examiner must be notified at ¶Yes 2□ No Funeral Director 11 mare 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11 Maritel Status Armed Forces?

1 Yes 2 No
If Yes, Give 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Wildowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT, use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: If flem 27 is marked other any injury or other traumatic event 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) anc raer e 19a. Informant's Name/Ralationship (Type, Print) Daught 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) 603 N. 95Kbur ine M. Baltimore 21216 tarrison 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State Carrison Forrest Vet. Com Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility Q | be r 21. Signature of Funeral Service La Signifle 23a-Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failura. List only one causa on each lina. Approximeta Intarval Between Onset and Death **Physician** Immediate Cause (Final disaasa or condition rasulting in daath) /Medical Renal Failure 50 days Examiner Examiner 50 days Hear ettending physician end for use as the bunel-transit Sequentially list conditions, if any, leading to immediata ceusa. Enter Underlying Cause (Disaase or Injury Dua to (or as a consaquance of) 5/10 60 days Division of Vital Records, P.O. Box 68760, AD CABG The law requires that the death certificate be by Physician/Medical that initiated avants resulting in death) Last Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the been signed by the should be detech 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings eveitable prior to completion of ceuse of daath? 24a. Was an autopsy performed? Completed certificate hes 1 Yes 27 NO 1 ☐ Yes 28 No Be 25. Was cese referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2√ No 1 Copatient 2 ER/Outpatient 3 DOA After this 27. Mannar of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Panding invastigation 1 Natural 1 Yas 2 No Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homtcida To the Hospital o within 24 hours en To the Funeral Di completely filled in edicai 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier AT 243894L September 21, 1998 aura 30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print) 201 E. Univ Paikway Howera HOSD ITAL Union Memoral Balhmar MD 21213 31. Data filad (Month, Day, Year) SEP 2 3 1998 32. Registrar's Signature

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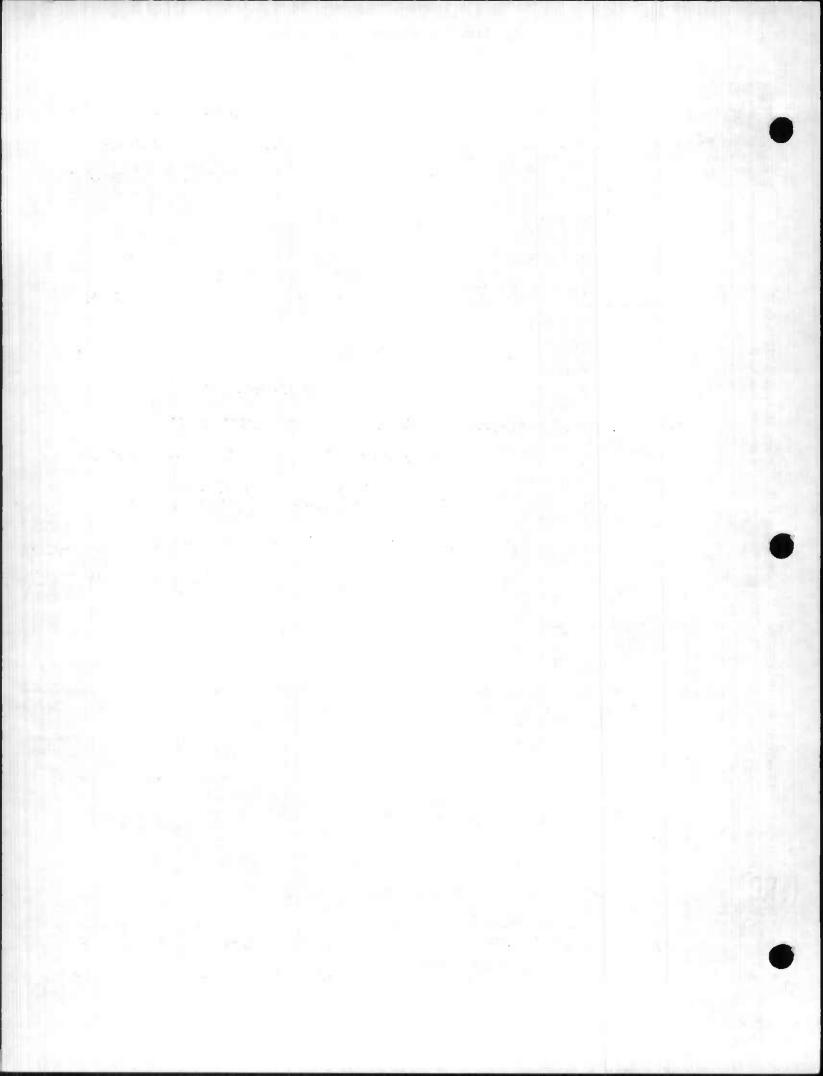
State Registra



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 5:30 AM ANNA M. MOONEY SEPTEMBER 20 1998 /Medical 4a Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Deeth 4c. County of Deeth Examiner ESSEX
If Under 1 Year | If Under 24 Hrs. 411 MARYLAND AVENUE BALTIMORE 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M 2 F 212035062 Yrs. 89 Director JUNE 8,1909 MARYL AND Usuai Residence of Decadent with the Maryland 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director BALTIMORE **ESSEX** 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code r than "naturel", or items 23s or the Medical Examiner must be 411 MARYLAND AVENUE USA Funeral filed within 72 hours after death Hygiena. 21221 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 11. Marital Status 1 Yes XXNo If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER 0 OWN HOME permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe eny Injury or other traumatic event ones. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be JOHN SRAVER ANNIE DEBELIUS 19a. Informent's Name/Relationship (Type, Print) 19h Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 411 MARYLAND AVENUE ESSEX, MD 21221 ROLAND E. MOONEY / HUSBAND 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 ◯XBuriai 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 9/23 OAK LAWN CEMETERY BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** ien Known Physician/Medical Examiner Duration the death certificate be axecuted physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 88 ed by the a Part II. Other alonificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Winknown þ 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of deeth? certificata has birector, page 2 s 1 Yes 2 No 1 Yes 22 No 25. Was case referred to medicai Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: on 5 Pending investigation 1 Alatural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide R 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es steted.

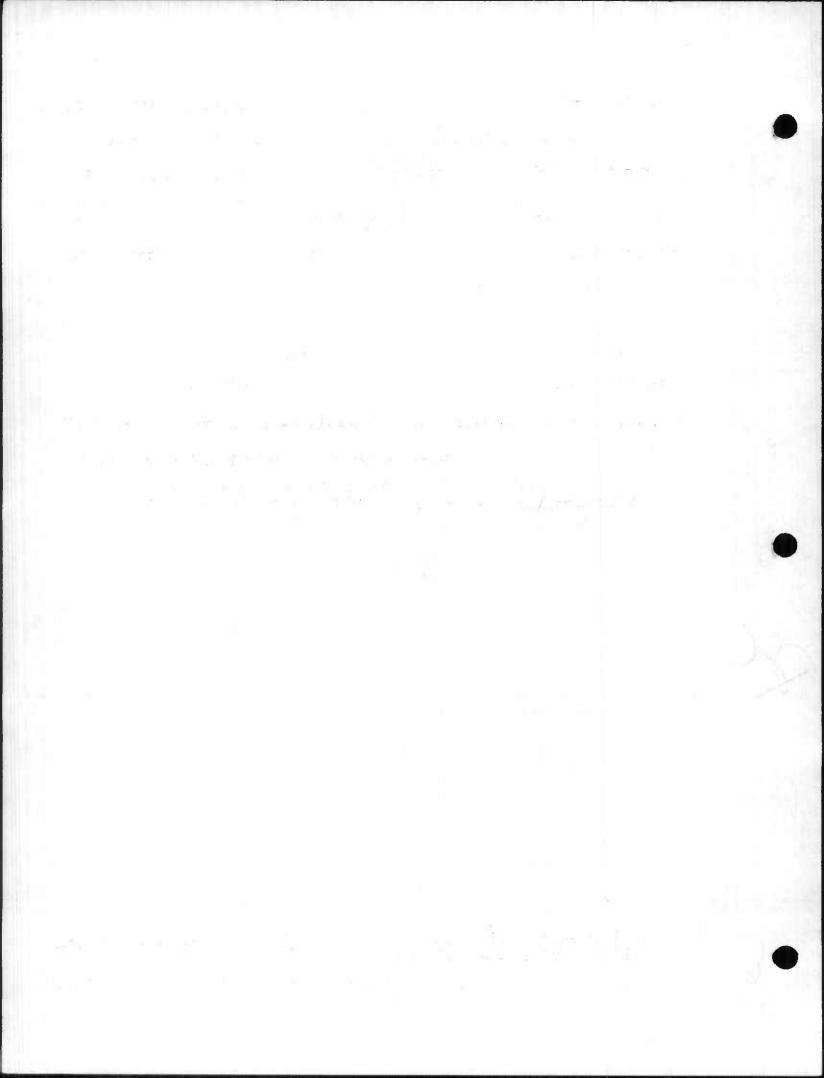
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end placa, and due to the cause(s) end menner steted. (Check only one) 29b. Signature and title of certifier 29c. License number D-38754 . 29d. Date signed (Month, Day, Y. 29d. Date signed (Month, Day, Year) 000 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN BLUD MD-21221 MALIKA NASBEM 404. MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State SEP 2 3 1998 Registrar

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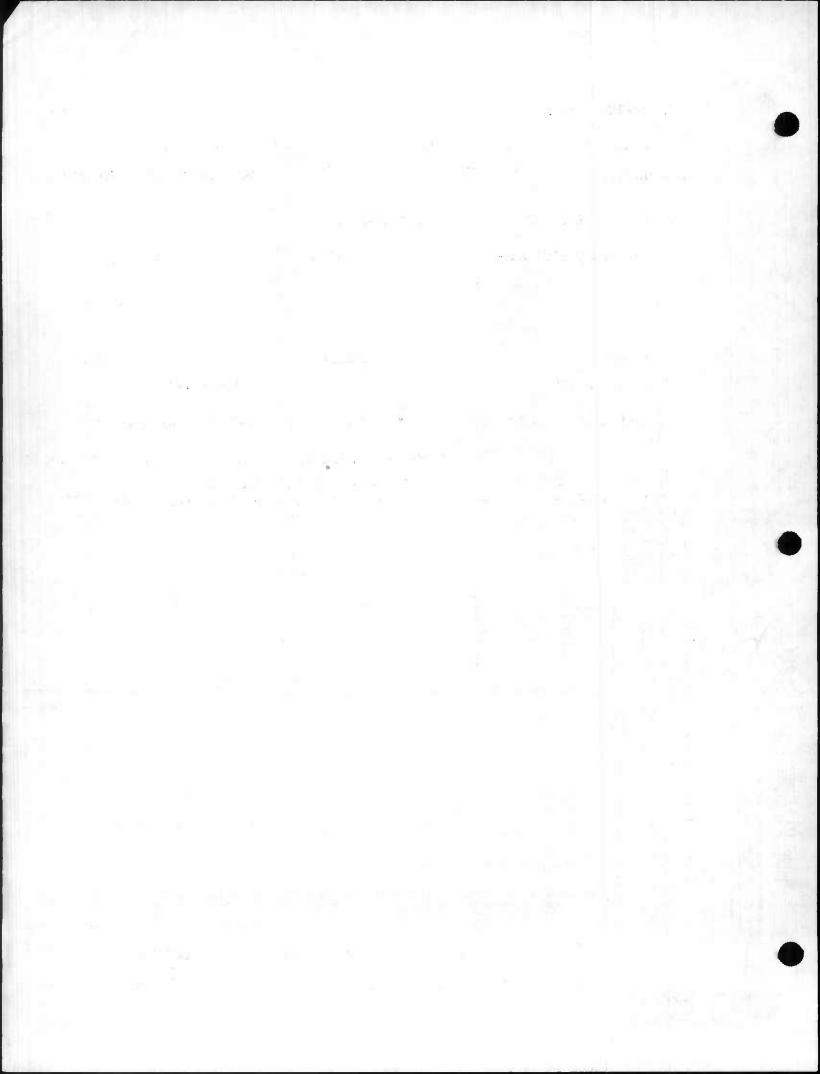
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	1. Decedent's Neme (First, Middle,			77 11 124	tificate of		2. Dete of De			Time of Death
ysician Jedical	Henry J. Nickel						sept.	22, Dey 199	Veer	8:35pm
aminer	4a. Fecility Neme (If not institution,			62		4b. City, Town, or		h 4c. County	of Deeth	
	Howard County			-	If Under 1 Year	Columb:			oward	
eral ctor	5. Sociel Security Number 215–09–3203 Usuel Residence of Decedent	6. Sex XOXM 2□ F	7. Age (In yrs.		Months Deys			3, 1909	9. Birthplece (Country) MD	Stete or Foreign
ti i	10a. Stete 10b. County		10c. Ci	ty, Town or Loc					10d. In	side City Limits
ctor	MD	N/A		Balti	imore Ci	ty			Ж	¥ Yes 2 No
at be notified	10e. Street end Number 1310 Hull Street				10f. Zip Code 21	230		10g. Citizen of Unite	What Country? d States	
the Medical Examiner must be notified at ompleted by Funeral Director	11. Meritei Stetus 1 Never Merried 20 Marrie 3 Widowed 4 Divorced	Armed F	V0		Ves Decedent of Yes, specify Cub	Hispanic Origin? (S sen, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	14. Red Bie Specify	ce - American Inc ck, White, etc. y: Whit	
eted bete	15. Decedent's (Specify only highest	s Education grade completed)		16e. Deced	ent's Usuel Occu	pation during most of wo	rking	16b. Kind of B	usiness/Industry	
r, the Medical	Elementery/Secondery (0-12) 5th Grade	Coilege (life. D	Longsho				Shipping	4
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ToB	Walter J. Nicke	1				Anna	Spickol	a		
	19e. Informent's Neme/Reletionshi		abte:			t and Number or Ru				
	Constance A. Kel. 20a. Method of Disposition	ry / Dau			Annapol	is Road,	Baltimo		land 212 City or Town, S	
5	120 urial 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Spe		State	cemetery, crem	atory or other ple porial Par		er 26,199			
	21. Signeture of Funerei Service Li	**				ess of Fecility tevens Fund			ole i di ji	
once	7500	000	er A	CL E		rt Avenue,			and 2123	0
	23a. Part1. Enter the disease, or coshock, or heart feilure. List or	complications that	caused the dea						Appr	oximete vel Between
ian cai	Immediate Cause (Final	7	lzheim	ore Di	50250				Onse	et end Deeth
ner	disease or condition resulting in deeth)	θ		V					3 3	years
je l			D0 00 (0	or es e consequ	dence on):				[[
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ledical	thet Initieted events resulting In deeth) Last	C	Due to (c	r es e consequ	ence of):				1	
lan		d							1	
Physician/M	Pert II. Other significant condition	s contributing to d	eath but not res	ulting in the un	derlying cause gi	ven in Pert I.	23b. Dld	tobacco usa co	entribute to the d	cause of death?
							10	Yes & No	3 Probably	4 Unknown
letec							24e. Wes	en eutopsy ormed?	available	on of cause
Somp							10	Yes XIX No		2/O(No
o Be C	25. Was case referred to medical examiner?					26. Plece of De	eth (Check only o	one)		
1-	1 ☐ Yes 2 ZONo	-		ER/Outpatient	3LI DOA		lome 5 Resi			
sation:	27. Menner of Deeth XX Netural 5 Pending 2 Accident Investiga	ition	of Injury th, Dey Year)	28b. Time of Injury	28c. Inju Wo	nyat irk?]Yes 2 □ No	28d. Describe	how Injury occur	Ted	
Certification:	3 Suicide 6 Could no determin	ed 286. Plece build	ing, etc. (Specif	y)	et, fectory, office		City or To	wn, Stete)	ber or Rural Roul	te Number,
edical Ce	29e. Certifier (Check only one) Certifying 2 Medical Ex	xaminer : On the b	best of my kno esis of examine ner steted.	wledge, deeth tion end/or invo	occurred et the ti estigetion, in my	me, dete end piece opinion, deeth occu	, and due to the irred at the time,	ceuse(s) and ma dete end pieca,	anner as stated. end due to the c	euse(s)
Medica	29b. Signature and title of certifier	1	D		29c. Licen	se number		29d. Dete signe	d (Month, Day,	Year)
	> Hag	warns	- N	(-D.	D1	4160		Septemb	er 23, 1	1998
	30. Neme end address of person w Harjit Sing					Highway	Baltin	more. N	Md. 212	225



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MARJORIF D. NAG 4a. Fecility Neme (It not institution, g Laylestow 5. Social Security Number 6. 145-26-2773 Usual Residence of Decedent 10e. State 10b. County MARYLAND BALT 10e. Street end Number 707 MAIDEN CHO 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	IMORE	e (In yrs. last birthda) Yrs. 10c. City, Town or I	If Under 1 Year Months Deys	Hours Min.	8. Dete of Birth	Ba	Year 9B of Death	6:42 ar
4a. Fecility Neme (If not institution, g Layles tow 5. Social Security Number 6. 145-26-2773 Usual Residence of Decedent 10e. State 10b. County MARYLAND BALT: 10c. Street end Number 707 MAIDEN CHO: 11. Marital Status 1 Never Married 2 Married	IMORE	e (In yrs. last birthda) Yrs. 10c. City, Town or I	If Under 1 Year Months Deys	Cator	S V 1 / 2 8. Dete of Birt	4c. County	of Death	
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MARYLAND BALT. 10e. Street end Number 707 MAIDEN CHO. 11. Marital Status 1 Never Married 2 Married							104	Innida City I Imite
10e. Street end Number 707 MAIDEN CHO		OAT	ONSVILLE				100	I. Inside City Limits 1 ☐ Yes 🏋☐ No
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	12. Was Decedenf	Ever in U,S. 13.		Hispanic Origin? (Speen, Mexicen, Puerto	ecify Yes or No-		e - American	Indian,
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23e. Pert1. Enter the disease, or cor	mplications that caused							21229 pproximete
shock, or heart feilure. List only	y one cause on each lir	ne.					in	nset and Deeth
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25. Was cese referred to medical				26. Place of Deeth	(Check only or	ne)		V
1 ☐ Yes 2 ☑ No			nt 3 DOA Oth	ner: 4 12 Nursing Ho	ne 5 Resid	ence 6 Othe	er (Specify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Dey	Year) 28b. Time of Injury	of 28c. Injur Wor	y et rk?	28d. Describe h	ow Injury occurre	ed	
	20							
	286. Place of Inju	ry - At home, farm, st . (Specify)	reet, factory, office		City or Tow	treet and Numbe n, State)	er or Hural H	oute Number,
Medical Exa	miner; On the basis of	examination and/or in	h occurred et the tin	me, date and plece, opinion, deeth occurre	end due to the c	ause(s) end mei ate end plece, a	nner as state	e cause(s)
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2 Silcottr	17. Fether's Neme (First, Middle, Last JOHN DEN HARTIC 19e. Informant's Name/Reletionship P. TODD NAGEL 20e. Method of Disposition 1	17. Fether's Neme (First, Middle, Last) JOHN DEN HARTIGH 19e. Informant's Name/Reletionship (Type, Print) P. TODD NAGEL (GRANDSON) 20a. Mathod of Disposition	17. Fether's Neme (First, Middle, Last) JOHN DEN HARTIGH 19e. Informant's Name/Reletionship (Type, Print) P · TODD NAGEL (GRANDSON) 1624* 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 20b. Plece of Disposition 4 Donation 5 Other (Specify) MEYERSV 21. Signeture of Funeral Service Licensee High Hig	17. Fether's Neme (First, Middle, Last) JOHN DEN HARTIGH 19e. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street P. TODD NAGEL (GRANDSON) 1624* ROBINWOOD 1624* ROBINWOOD 24* ROBINWOOD 1624* ROBINWOOD 1624* ROBINWOOD 1624* ROBINWOOD 1624* ROBINWOOD 1624* ROBINWOOD 1624* ROBINWOOD 1624* ROBINWOOD 1624* ROBINWOOD 1624* ROBINWOOD 1624* ROBINWOOD 1624* ROBINWOOD 1624* RO	18. Mother's Name (First, Middle, Last) 18. Mother's Name 17. Fether's Name (First, Middle, Last) 19b. Malling Address (Street end Number or Run 1624* ROBINWOOD AVENUE-1 1625* ROBINWOOD AVENUE-1 1	18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Double 18. Mother's Name (First, Middle, NELLIE VAN VI 19e. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number of Paral Route Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments of Comments of Comments (Number of Comments) 19b. Malling Address (Street and Number or Rural Route Number of Comments of	18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumant JOHN DEN HARTIGH 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number of Pruntal Route Number. Ctry or Town, P. TODD NAGEL (GRANDSON) 1624* ROBINWOOD A VENUE—LAKEWOOD, OHIO Dete 20c. Location 1 20b. Place of Disposition (Nume of Dete 20c. Location Service) 10b. Mailing Address (Street and Number of Runtal Route Number. Ctry or Town, 1 10b. Mailing Address (Street and Number of Runtal Route Number. Ctry or Town, 1 10b. Mailing Address (Street and Number of Runtal Route Number. Ctry or Town NELLIE VAN VILIET 10b. Mailing Address (Street and Number of Runtal Route Number. Ctry or Town NELLIE VAN VILIET 10b. Mailing Address (Street and Number of Runtal Route Number. Ctry or Town, 1 10b. Mailing Address (Street and Number of Runtal Route Number. Ctry or Town NELLIE VAN VILIET 10b. Mailing Address (Street and Number of Runtal Route Number. Ctry or Town NELLIE VAN VILIET 10b. Mailing Address (Street and Number of Runtal Route Number. Ctry or Town NELLIE VAN VILIET 10b. Mailing Address (Street and Number of Runtal Route Number. Ctry or Town Ordereity, Cemeratory or other place) 10b. Mailing Address (Street and Number of Runtal Route Number. Ctry or Town Nelling Number of Runtal Route Number. Ctry or Town Nelling Number of Runtal Route Number. Ctry or Town Nelling Number of Runtal Route Number. Ctry or Town Nelling Number of Runtal Route Number. Ctry or Town Nelling Number of Runtal Route Number. Ctry or Town Nelling Number of Runtal Route Number. Ctry or Town Nelling Number of Runtal Route Number. Conditions and Runtal Route Number. Cheek on Place of Runtal Route Number. Cheek on Place of Runtal Route Number. Cheek on Place of Runtal Route Number. Cheek or Place of Runtal Route Number. Runtal Route Number. Runtal Route Number. Runtal Route Number. Runtal Route Number. Runtal Route Number. Runtal Route Number. Runtal Route Runtal Route Number. Runtal Route Runtal Rou	17. Fehrer's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) 19. Informati's Name/Reletionship (Type, Print) 19. Malling Address (Street and Number or Rural Route Number, Oyo Town, State, Zip C. P. TODD NAGEL (GRANDSON) 16.24* ROBINWOOD AVENUE—LAKEWOOD, OHIO 44.107 16.04* ROBINWOOD AVENUE—BALTIMORE, MRYLAND 16.04* ROBING ROB



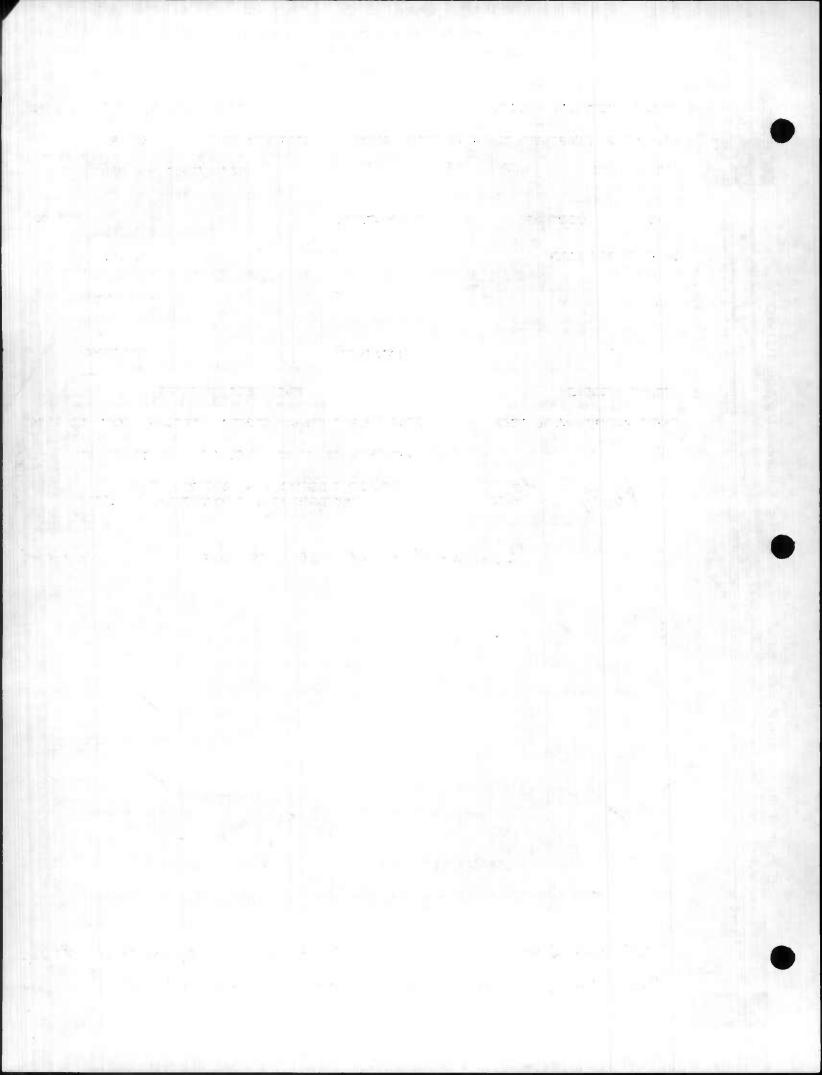
State of Maryland / Department of Health and Mental Hygiene

							Certific	cate of	Death		B	eg. No.	7. U.	23198
	Dharia	·	1. Decedent's Nama (First, Midd	lia, Last)							2. Data of Deal Month	th Day	Yaar	3. Tima of Death
	Physic /Medi		MAE		NICHO	OLS					Septemb			8:00 am
	Exami		4a. Facility Nama (If not institution	on, giva street and num	ber)				4b. City, Tow	vn, or Lo	cation of Death	4c. Count	ty of Death	
	_		710 Montgomery						Laur			Prin	nce Ge	eorge's
	Funeral Director		5. Social Security Number 214–54–7294	6. Sax 1□ M N	7. Aga (In yrs 92		rs. If U	ndar 1 Yaar iths Days		Min.	8. Data of Birth (Month, Day Jan. 2	Year) 1906	Coun	iaca (Stata or Foraig stry) yland
	D .		Usual Rasidance of Decedant 10a. Stata 10b. County	,	10c C	ity Town	or Location						14	Od Incide City Limit
	e Maryla Ba-f shor	Director	Md. Princ	ce George's		aure								0d. Insida City Limite 1 X Yas 2 □ No
	or 2	Dire	10e. Street and Number				10	. Zip Coda			1	0g. Citizan of	What Coun	try?
	eth v	rai	710 Montgomery					2070				USA		
020	72 hours efter deeth with the Maryland natural; or Items 23a or 28a-f show digat Examiner must be notified at	by Funeral	11. Marital Status 1 □ Nevar Married 2 □ Mar 3 ☒ ※ Idowed 4 □ Divorced	H Vac Chia	ces? 2 E No	J,S.	If Yas,	ecedant of specify Cub as 2⊠Xo	oan, Maxican,	in? (Spe Puarto I	ecify Yas or No- Ricen, atc.)	Bla	ice - Amaric ack, Whita, i iiy: Whi	atc.
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Σ.	Health Health Iem 27 i		Peggy Anderson	/ daugh					y Stre	eet	Laurel	Md.	20707	,
Baltimore, Maryland 21215-0020	00 45 ==		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 4 ☐ Donetion 5 ☐ Othar (S		tata	cemeter	Disposition y, cremetory TY'S	or other pla			ep 25,	20c. Location Laure	· City or To	
Ball	permit. Page Depertment of important: If any injury or once.		21. Signature of Funaral Sarvice	Licansee			Dona	aldsor		cal I	Home, P.			20505
	-		23a. Part1. Entar tha disaasa, o	r complications that ca	usad tha daa	th. Do n					Laure		Tand	20707 Approximata
	Physician		shock, or haart failura. List	only ona ceusa on aa	ch lina.								i	intarval Batween Onsat and Death
7	/Medicai		Immediata Causa (Final disaasa or condition	CONIG	ESTI	E	HEAR	T FA	The	=			1	7 20 -15-66
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-	70 ##	iner		- CRIT	ICAL	A	DETIC.	VALU	E STE	5005	51.5		-	1 YEARS
	death certificate be executed e attending physician end of for use es the bunal-transit	Examiner	Sequentially list conditions,	6.			onsequance						I	1000
Š,	se exercian cian e		Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury										-	
68/60,	physic the t	edical	that initiated evants resulting in daath) Last	Ü	Dua to (or as a c	onsequanca	ot):						
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5	thet the death ce ed by the attendi deteched for us	by Physician/	Part li. Other significant condition	ons contributing to dea	ith but not ras	sulting in	tha underlyi	ng causa gi	ivan in Part I.					the cause of death
7	thet ded by dete	y P	LEFT INTERNAL	AROTIO AR	TREY.	STER	12 SE	CERE	BÉO -		1 🗆 Y	ee 2 1 No	3 ☐ Prot	bably 4 Unknow
ds,	requires that een signed b hould be dete	d b			,						24a. Was a	n autopsv	24b. Wa	are autopsy findings
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2			25. Was cesa rafarrad to medice		CACKE		0140		26 Piece	of Death	(Check only on] Tas 2 140
or vital Record		To Be	axaminer? 1 ☐ Yas 2 ☑ No	Hospital:	patient 2	EB/Out	patient 3	DOA Ot	do a se		ma 5 PRaside		ther (Specifi	v1
0	g Phys er this eral d		27. Mannar of Death	28a. Data of	Injury	28b. T	ima of	28c. inju			28d. Dascribe ho			7
0	tending P death. tor: After the funer	atio	1 ☑ Natural 5 ☐ Pandir 2 ☐ Accidant invasti		, Dey Year)		jury M		Yas 2□N	lo				
UNISION	A company	Certification:	3 ☐ Suicida 6 ☐ Could 4 ☐ Homicide datam	nined 286. Place C	of injury - At h g, etc. <i>(Spaci</i>	ome, fer	m, straet, te	ctory, office		4	28f. Location (St City or Town		ber or Rura	l Routa Number,
	Hospital Andreas	edical C		ng Phyeiclan: To the b Examiner: On tha bas end manna	is of axamina									
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) L'alla	_ MO				D:	22 15	5		SEPTE	MGEY.	22 1998
7			30. Neme and addrass of person		ot daath (itar	m 23a) (Type, Print)							
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TO THE SHEET OF THE SHEET OF 5 . 2 75 0524 PD 2-24

State of Maryland / Department of Health and Mental Hygiene

						(Certifica	te of	Death			Reg. No.	0 6	. 2103	
			Name (First, Middle	e, Last)	200						2. Dete of De	eth .	Maria	3. Time of Death	
	Physician	EUGENI	A VICTOR	IA POLUNA	S						Month SEPTEME	Day	1998	4:40AM	
	/Medical Examiner	4a English Mr	ame (If not institution						4b. City, To	wn, or L	ocation of Death	-	ly of Death	1.10141	
	Examiner		GNES REHAL	BILITATIO	N & M	JRSING	CENTER		ELLI	COT	r CITY	Н	OWARD		
	Funeral Director	5. Social Sec 213-20		6. Sex 1 ☐ M 2 CXF	7. Age (In 7.	yrs. lest birthe	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 04/20/]	h y, Year) .923	Coun	lace (Stete or Foreign try) LAND	
	70		nca of Decedent												
	ehow of	10a. Stete	10b. County		100	c. City, Town o	or Location						10	Od. inside City Limits	
	oto cto	MD	BAL	TIMORE		CAT	CONSVII	LE						1 ☐ Yes 2√ No	
	ath with the Marylar s 23s or 28s-f show must be notified at a real Director	10e. Street ar	nd Number				10f. Zi	Code				10g. Citizen of	What Coun	try?	
	th wi	36 DUN	WEGAN ROA	AD				212	28			U	.S.A.		
20	or item		etus r Married 2 Marr wed 4 Divorced	if Yes. G	orces? 2[XNo live	in U,S.	13. Was Dece if Yes, spe 1 Yes				pecify Yes or No Ricen, etc.)	Speci	ack, White,	etc.	
21215-0020	"natural",		15. Deceden		Dates.	16a D	ecedent's Usu	ai Occur	nation			16b. Kind of I	Ruelnese/Inc	lustry	
15	c		(Specify only highes	st grede completed)	1 (0	give kind of wi	ork done	during mos	t of work	king	iosity			
12	filed within Hygiena. ther than "ent, in West, i	Elementary	//Secondary (0-12)	College	(1-4or 5+)		HOMEMAK					0	WN HON	Æ.	
	E T # E		Name (First, Middle,	Last)					18. Mothe	er's Nam	e (First, Middle,				
Maryland	D 2 0 0 m		GI TRUDT							Can					
2	2 should be end Ments in marked sumatic e		SLIBURIS nt'a Name/Relations			195 A	Asiting Address	s (Street		-	ETH_KUB] rel Route Numbe		Code)		
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e,	My Health item 27 other tr	20a. Method		DAUGHIER		Ob. Place of D			EARCI	CII	Date Date	20c. Location		MD 21042	
Baltimore,	of the	1 X Buria 4 □ Dona	al 2 Cremation ation 5 Other (S	pecify)	State	HOLY REDEEMER CEMETERY 9/19/98 BALTIMORE, 22. Name and Address of Facility									
Bai	permit. Pag Department Important: I any injury o	21. Signature	Sullen	NERAL HO			228								
		23a. Part1. E shock, o	inter the disease, or or heart failure. List	complications that only one cause on	caused the each line.	death. Do no	enter the mo	de of dyi	ng, such as	cerdiac	or respiratory a	rest,	1	Approximate interval Between Onset and Death	
	Physician /Medical Examiner	immediate Cause (Final disease or condition resulting in death) a. Cucnora of Breast Met. to liver Due to (or a da consequence of): b.													
68760,	certificate be executed nding physician end use as the burial-transit nr/Medical Examiner		dist conditions, g to immediate Underlying ase or injury events	С		to (or as a co									
	A Ba		eath) Last	d	000	10 (01 63 & 001	isoquence or)								
.O. Box	that the death ceed by the ettendidetached for use	Part It. Other	significant condition	ons contributing to	death but no	t resulting in t	ne underlying	ceuse gi	ven in Part	i.		_/		the cause of death?	
S, P	igned by be deta										10	Yee 2 No	3 Prot	bably 4 ☐ Unknown	
Vital Records	aw requin										24a. Was perfo	an autopsy med?	ava coi	ere autopsy findings allable prior to mpletion of ceuse death?	
Œ	The land page										101	res 20 No	10	Yes 2000	
ita	iclan: The certificata rector, page Be Co	25. Was cese	referred to medice						26. Place	of Dea	th (Check only o	ne)			
>	Physician: this certific ral director, TO Be (examiner	20 No	Hospital:	inpatient	2 ER/Outp	atient 3 D	OA Ot	ner: 4 Nu	ursing H	ome 5 Resid	dence 6 🗆 O	ther (Specif	y)	
on of	Attending Phy if death. Ector: After this by the funeral filcation: T		al 5 Pendin	28a. Date (Moi	of injury oth, Dey Yea		ne of	28c. Inju Wo	_		28d. Describe			,	
Division	pal or Attending P is after death. bit Director: After the ed by the funera certification:	3 ☐ Suici 4 ☐ Hom	dotorm	not be ined 28e. Piac build	e of injury - ding, etc. (S)	At home, farm	, street, facto	y, office			28f. Location (: City or To	Street end Nun vn, Stete)	nber or Rure	l Route Number,	
-	To the ideapted or within 24 hours after To the Eurocki Dire completely filled in b		12 Certifyin 2 Medicai	g Physician: To th Examiner: On the t and me	e best of my basis of exa- nner stated.	knowledge, omination and/o	leath occurred or investigation	at the ti	me, date en opinion, des	d plece, th occur	and due to the red et the time,	cause(s) and r date and place	nanner as st e, and due to	ated. the ceuse(s)	
1	Me the		e and title of certifie				29	c. Licen:	se number	number 29d. Dete signed (Month, Dey, Year)				Dey, Year)	
	FSFO	16	esta Olla	Ar-				7.	1/17	01		leake	4, 10	2 1000	
	10	30. Name and	l address of porson	who completed and	ise of dooth	(Item 23a) /T-	(ne Print)	1)	27/	0/	4	syrem	21	1001=	
		710	(Month, Dey, Year)	who completed cau	HO10	CE L	ANC	- B	ACT	ð	MD	2122	-8 CH	R. GRAH	
	State Registrar	31. Date filed	SEP 2 3	1998	Registrar's S		b. 1	bank	61						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 650 pm Dey PAYNE GEORGE SEPTEMBER 20 1998 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE SECOURS HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) Deys Hours Min 10 M 20 F 213-32-2954 Usuel Residence of Decedent Yrs. MD 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 Vea 2 No NIA BALTIMORE MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Kogo 4262 TLOWERTON 21229 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 ☐ Never Merried 2 ☐ Married Specify. BLACK 1 Yea 2 No 3 Widowed 4 Divorced 15. Decedent'a Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) NIA AB LECH GED 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) SAVOY MARY GEORGE TAYNE 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) DONNA 5971 KD. BALTO. **HIMUCO** AUGHTER 20b. Plece of Disposition (Neme of cemetery, crematery, or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 9-24-98 4 ☐ Donetion 5 ☐ Other (Specify) JARRISON FOREST WINGS 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility VAUGHN C. GREENE FUNBRAL 23a. Pert1. Enter the Disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. 21229 MD. Approximete Intervel Between Onset end Deeth Immediete Cause (Finel disease or condition resulting in death) SEPSIS Due to (or es e consequence of) NEUMONIA Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): ESPIRATOR Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No ERKALIMIA 24a. Wes en eutopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

10e. Stete

Director

Funeral

þ

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examere.

Baltimore, Maryland 21215-0020

the Menyland

Examiner trans Physician/Medical **BSD** P Completed

Be

Certification: To

Division of Vital Records, P.O. Box 68760 or Attending Physicien: ofter Hospital • Funeral within 2 To the I

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

BRADYCARDIA.

25. Wes cese referred to medicel exeminer?

1 Yes 3000 27. Manner of Deeth Naturel 5 Pending investigation 2 Accident

6 Could not be determined 3 Suicide 4 Homicide

Hospital: Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Yeer)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

24b. Were eutopsy findings evalleble prior to completion of cause of death?

1 ☐ Yes 2 No

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury et Work? 1 ☐ Yea 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

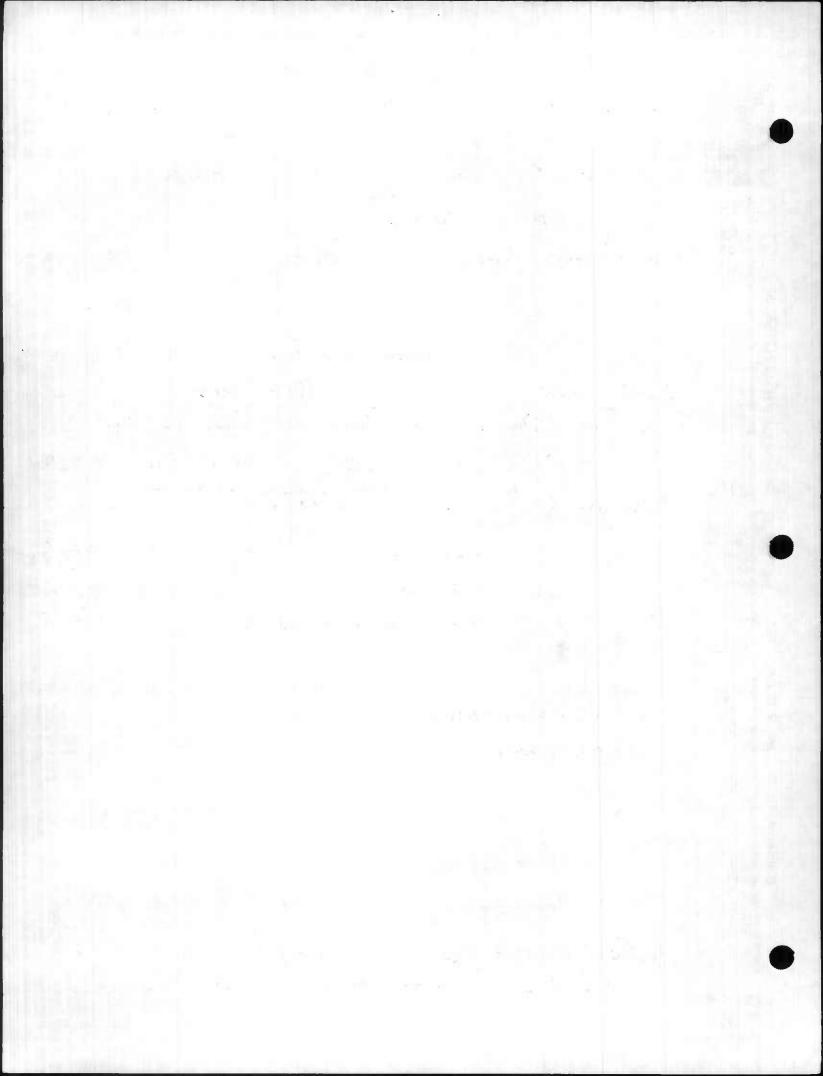
15 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

TIMORE NO 2120 # 407 5

31. Dete filed (Month, Dey, Yeer) SEP 2 3 1998 32. Registrer's Signature

State Registrar



.K.S TEPHEN PRYCZ		State of Man	land / Depa	artment of I	lealth and		_	20101			
Physician	1. Decedent's Nama (First, Middle	Last)	Pryca	rtificate of zka	Death	2. Date of De Month		3. Time of Death 9:09 PM			
/Medica Examine	An English Mann of the net involvation				4b. City, Town, o	or Location of Death	4c. County of				
Funeral Director			70 Yrs.	If Undar 1 Year Months Days		rs. 8. Date of Bir in. (Month, De	y, Year)	D. Birthplaca (State or Foreign Country) Maryland			
arylend	Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits 1 ★ Yes 2 No			
Office death with the Maryland riters 23s or 28s-f show riter must be notified at	MD N/I		Baltimo	10f. Zip Code 212	22		10g. Citizen of Wh	at Country?			
9 2 2		12. Was Decedent Eve Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates:				(Specify Yes or No erto Rican, atc.)	14. Raca - Black,	Raca - American Indian, Black, White, etc.			
Baltimore, Maryland 21215-0020 semit. Peges 1 and 2 should be filed within 72 hours after Deperment of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or its ny injury or other traumatic event, tra Medical Examination. To Re Compileted by En		s Education	16a. Deced (Give life. I	dent's Usual Occup kind of work done DO NOT use retire aintanc	during most of w	vorking	16b. Kind of Busi	ness/Industry 1 Company			
yland be filed Mental Hyger other aftic event,	17. Father'a Name (First, Middle, L		czka		18. Mother's N		, Maidan Sumama) uick				
Maryla d 2 should the end Men 7 is marke traumatic	19a. Informant's Name/Relationsh		19b. Mailir				er, City or Town, St	ssex, MD2122			
altimore, IV nit. Peges 1 and ioniment of Health ortnament of Health injury or other ir.	20a. Method of Disposition 1 ABurial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from State	20b. Place of Disponentery, cremetery, cremetery	osition (Nama of matory or other pla Heart o	f Jesu	sept.	20c. Location - C	ity or Town, State imore, MD			
Baltim Baltim Bernit. Per Depertment important: any injury page.	21. Signature of Fugeral Service L 23a. Part1. Enter the disease, or shock, or heert failure. List of	L. Neiser	2	134 Wil	low Sp	ring Ro	ad, Balt	thews F.H. imore, MD212 Approximate Intervel Between Onset and Death			
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Due	PULMONARY EMBOLUS Due to (or as a consequenca of): RIGHT HIP FRACTURE								
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88	resulting in death) Lasf	d	Due to (or as a consequenca of):								
15, P.O. Box 6877 res that the decar comment igned by the amending physics by detached for use as the the by Physician/Medical			ributa to the cause of death								
requirements						24a. Was	an autopsy ormed?	24b. Were autopsy findings eveileble prior to completion of cause of death?			
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Vision of Attending Phy ar deeth. •ctor: After this by the funeral d	NEA -	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	f 28c. Inju		28d. Describe how injury occurred SUBJECT FELL OFF STOOL					
Division or Attending Perfector: Attent lin by the funers entitication:	3 Suicida 6 Could n 4 Homlcide determi	ot be		28f. Location (Street and Number or Rural Route Number, City or Town, State) BALTIM 6530 PARNELL AVENUE MARVIA							

werel Director: After this certificate has been signed by the atter filled in by tha funeral director, pege 2 should be datached for To the Hospital or Attending Physician: The law requires that the deap within 24 hours efter deeth. To the Funeral Director: Al

Physicia by Be Completed Medical Certification: To

29a. Certifier

6 Could not be determined 3 Suicida 4 Homicide

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State) BALT IMORE, 6530 PARNELL AVENUE MARYLAND Certify on Tysicien) To the best of my knowledge, death occurred at the time, date and placa, and dua to the causa(s) and manner as stated.

The property of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Sig

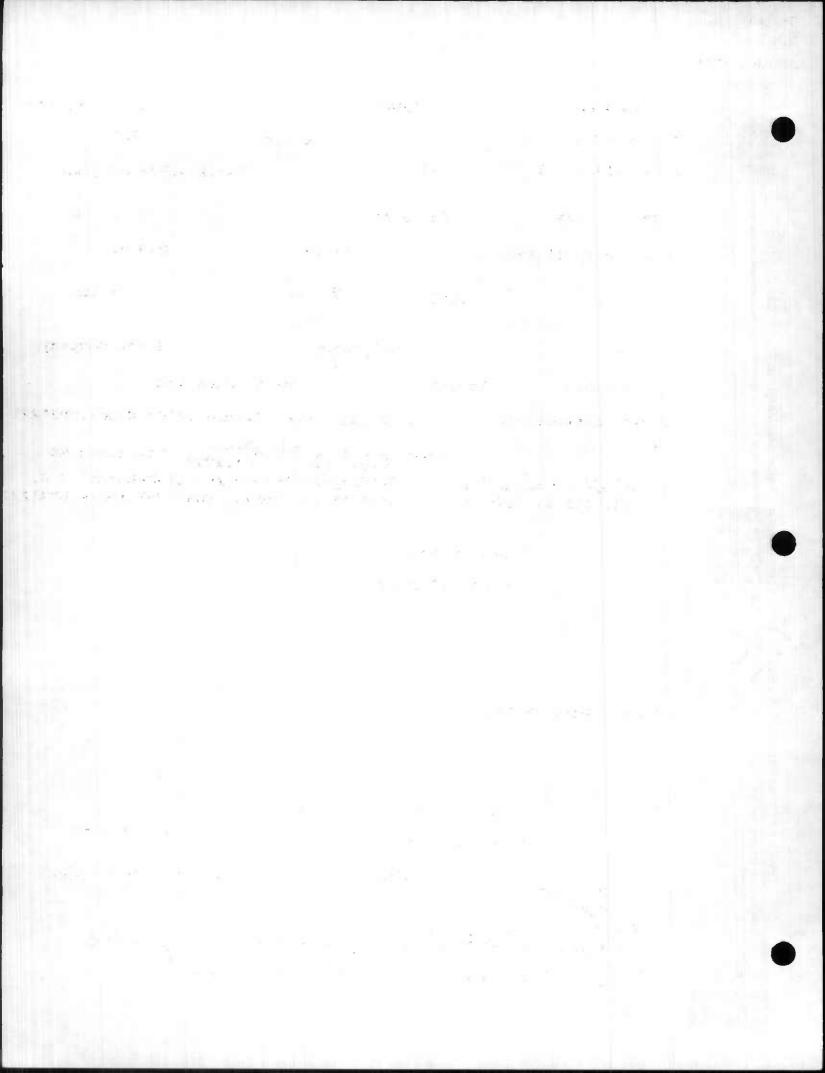
29c. License number

29d. Date algned (Mojith, Day, Year)

o completed cause of death (Item 23e) (Type, Print) SMIACEK, //(

State Registrar

32 Registrer's Signeture 31. Date filad (Month, Day, Year) SEP 2 3 1998

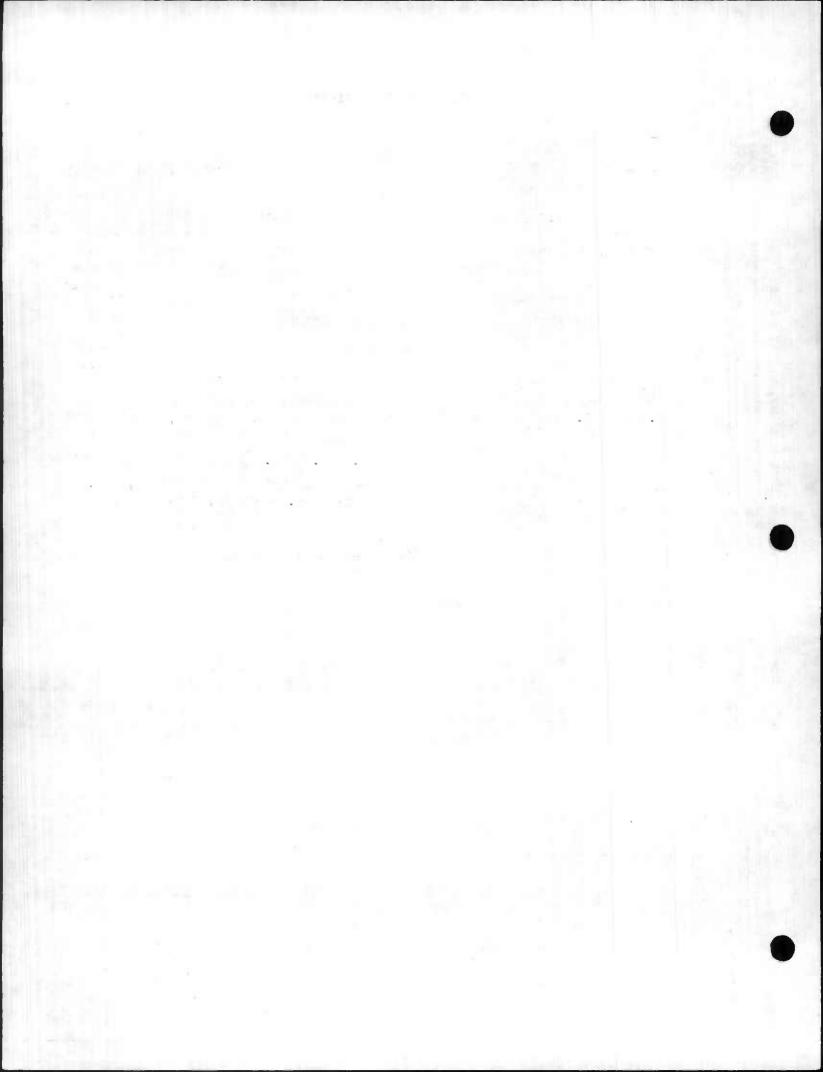


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Lillian Cecelia Pointer Month **Physician** September 20,1998 9:00 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1707 Inverness Avenue Dundalk Baltimore ff Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 17,1924 **Funeral** Days Months Hours 1 M 2 NF 217-16-8548 74 Maryland Director Usual Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 Tho Director Dundalk Maryland Baltimore 'natural', or Items 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1707 Inverness Avenue 21222 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2∰No If Yes, Give Yeer or Dates: 1 Never Merried 25 Merried altimore, Maryland 21215-0020 White 1 Yes 20XNo Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 Years 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental h Pages 1 and 2 should be Helen Skweli Walter William Novak Lo 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Orvil L. Pointer (Husband) Department of Health Important: If Nem 27 I 1707 Inverness Avenue Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross P. Nat. Cath. 9/23/98 Dundalk, Maryland 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset end Deeth 23a. Part1. Enter the disease shock, or heart failure. Physician /Medical immediate Cause (Final hetestatic lung carce disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown signed t Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? The law page 2 1 ☐ Yes 6 No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this centifica 8 25. Wes case referred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 5 4 Homicide a Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hours To the Funer completely fil 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (hem/23a) (Type, Print) EATTER AVE, BALTIMURE MP 21224 PURTEI JUBUNL 4940

Registrar

State

32. Registrar's Signature

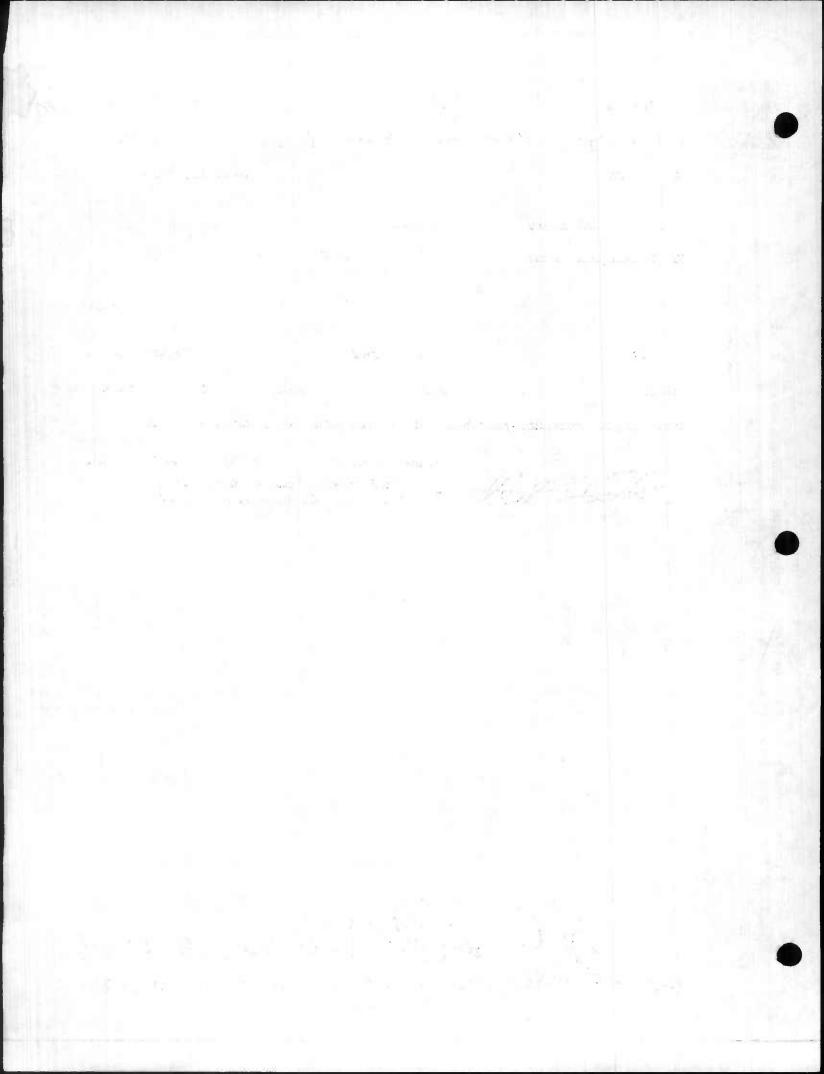


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Month 9 Hona 2:15 PM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Toppe 509 guson 5. Sociel Security Number if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) **Funeral** Deys 1 □ M 2 1 ℃ F Yrs Director 188-03-2459 Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No Md. Baltimore Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 Herns 23a 21286 USA 808 Mockingbird Lane Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 72 hours aftar 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 6 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 ⊠ Widowed 4 □ Divorced "natural", White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiena. Int: if Item 27 Is marked other than "r Elementery/Secondary (0-12) College (1-4or 5+) Package Goods 12 Bookkeeper 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) Be Hilt. Rahn Cora S. Arthur 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 Is any injury or other trau once. Mrs. Nanette Rosendale/daughter 926 Beaver Bank Cr. Towson, Md. 21286 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Suriai 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 9/26/98 Woodlawn Cemetery Woodlawn, Md. 21. Signature of Furious 8 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enten the mode of dying, such as cerdiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Physician/Medical to (or as a consequence of): Records, P.O. Box Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ata has been signed page 2 should be da þ 24b. Were eutopsy findings evallable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? certificata 1 Yes 2 INO 1 ☐ Yes 2 2 No Division of Vital lal or Attending Physician: The safter death.

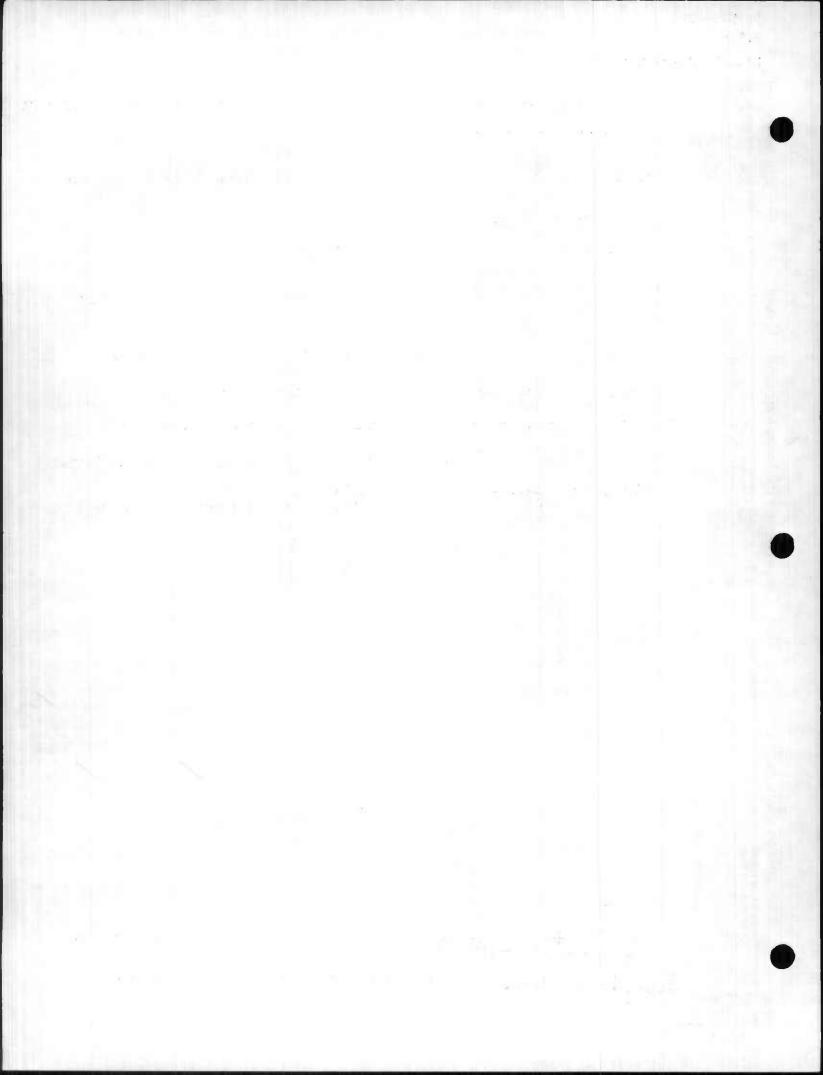
I Director: After this certificate of in by the funeral director, pa Be 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) Other: 42 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1/2 Naturei 5 Pending Investigation 1 ☐ Yes 2 ☐ No ☐ Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hoapital within 24 hours a To the Funeral D completely filled Certifying Physician: To the best of my knowledge, dyalh occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Engineer Profile basis of examination and the myesting start, in my opinion, death occurred at the time, date and place, and due to the Medicai 29a. Certifier ner: On the basis of examiner stated. n, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) 29b. Signature and title of ce 29d. Dete signed (Month, Dey, Year) 0 30. Name and address of 23a) (Type, Print) M.D. Ayman Akkad Dr. Towson, Md 7600 Osler 32. Registrar's Signeture 31. Dete filed (Month, Day, Year) SEP 2 3 1998 State Registrar



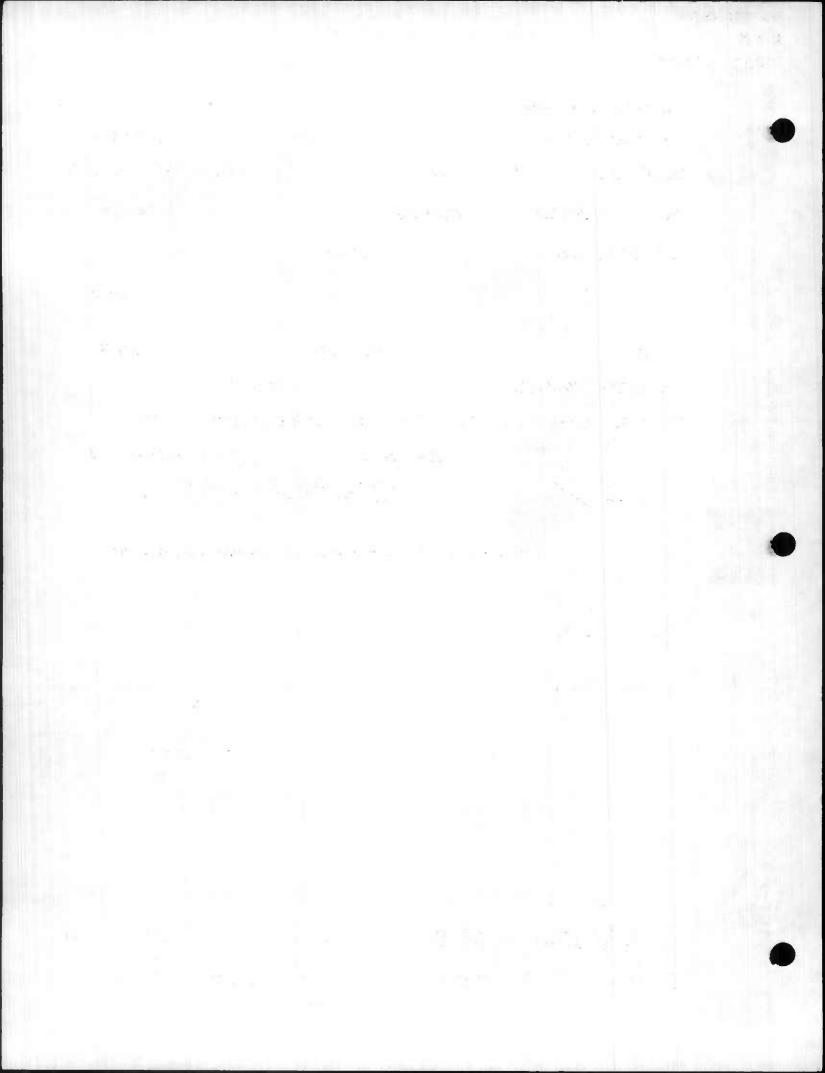
	RICHARD	PC	OSTORINO ITEMS: #23 tems: 23 part 1,27 pe	State of I PART I, 27 r MEO G-763	Marylar PER ME 9/29/	nd / De 0 676 98 re	epartmen ertificat	t of H	lealth a	and M	ental Hy	giene Reg. No.	2	9194		
			1. Decedent's Name (First, Middle, La	st)				- 4			2. Date of Dea		Year	3. Time of Death		
	Physicia /Medica	ai	RICHARD JOSEPI								SEPT.	7, 199	8	2334 PM		
	Examine		4a Facility Name (If not institution, giv FALLSTON GENERA						FALL	STON	cation of Death	4c. County	ORD			
	Funeral		Social Security Number 6. S	Sex 7.	Age (In yrs.	last birth	Months	1 Year Days	if Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Yea <i>r</i>)	9. Birthp	place (State or Foreign htry)		
	Director	-	218-17-4376 Usual Residence of Decedent	X	20	11	s.				Feb 15	, 1978	Mar	yland		
	Mend we		10a. State 10b. County		10c. Ci	ty, Town	or Location		-				1	Od. Inside City Limits		
	Men	to	Maryland Baltimon	re County	7	Coc	keysvi1	le						1 ☐ Yes 2 No		
	or 28,	Directo	10e. Street end Number				10f. Zip	Code				10g. Citizen of What Country?				
	23a c	la	5 Norgate Court					210					SA			
21215-0020	n 72 hours effer death with the Meryland "natural", or frams 23a or 28a-f show odds! Examiner must be notified at	by Funeral	11. Maritai Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 It Yes, Give Year or Date	ss? No),S.	13. Was Deced If Yes, special 1 Yes	37	dispanic Ori an, Mexicer Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bia Specii	ce - Americ ck, White,			
0-10	2 hou		15. Decedent's E	ducetion		16a. C	ecedent's Usu	el Occup	oation	A mil sometel		16b. Kind of E	iusiness/In	dustry		
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and	be fill H off	Be	17. Father's Name (First, Middle, Last						18. Mothe	er's Name	(First, Middle,	Maiden Sumer	ne)			
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ē,	s 1 end f Heelth Item 27 other tr	-	Mr. & Mrs. Peter 20a. Method of Disposition		20b. I	Piace of D	isposition (Nar	me of		ocke	ysville Date	20c. Location	21030 - City or To	own, State		
30	0 0		1 Burial 2 ACremation 3 C		110		Mount C			i	/12/08	Roltine	250	Maryland		
Baltimore,	Property .		21. Signally of Funeral Service Door			/12/90	Daltin	ne,	racytanu							
ä	Dep Impo		22. Name and Address of Facility Mitchell-Wiedefeld Home 6500 York Road, Baltimore, Maryland 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Interval Browse													
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) RIGHT VENTRICULAR CARDIOMYOPATHY a. Due to (or es e consequence of):												Interval Between Onset and Death		
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9 xo	aath certificate be executed attending physician and for use es the burial-transit	n/Medical	that initiated events resulting in death) Last	d	Due to (d	or as a co	nsequence ot):						1			
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			J. Tul	mer,	VI.D			0.0	C.M.E			SEPI	. 8,	1330		
			30. Name and address of person who	completed cause of	ot deeth (iter	m 23e) (T 111	ppe, Print) Penn St	ree	t, Ba	ltim	ore, Ma	ryland	21201			
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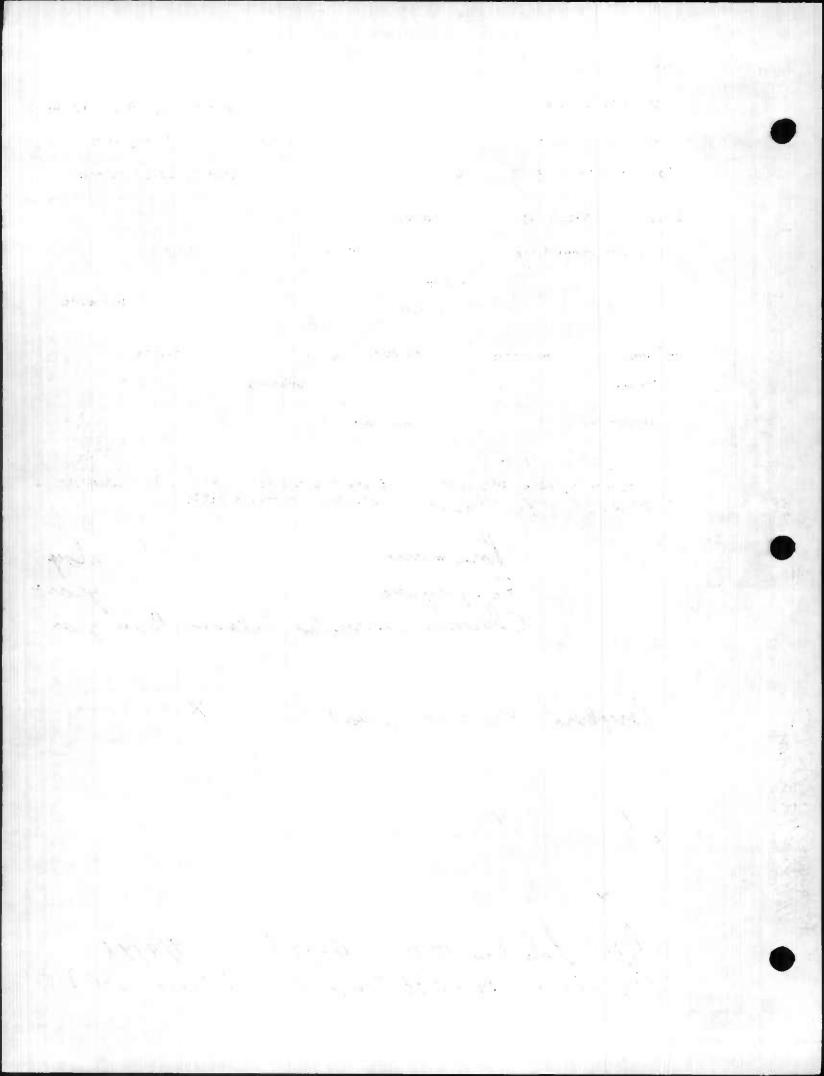


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OX 68760, certificate be associated to ding physician end the burial-transit to any Medical Examiner	Immediate Ceuse (Final disease or condition resulting In deeth) Hypertensive Arteriosclerotic Cardiovascular Disease Due to (or es e consequenca of): Due to (or es e consequenca of): b. Due to (or es e consequenca of): if eny, leading to immediate cause. Enter Underlying Ceuse, (Disease or Injury C											ease		
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DIVISION C blu o'Attending P off a fee death. off Division: Affect filled in by the funeral	3 ☐ Suicide 4 ☐ Homicide	6 Could not b	286. Place of	Injury - At h , etc. (Speci	ome, ferm,	street, fector	y, offica		28f.	Location (S City or Tox	Street end Nu m, Stete)	m <i>ber</i> or Ru	ral Route Number,	
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DHMH 16 Rev 6/95



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81	Decedent's Name (First, Middle, Last)	2. Date of D	Deeth 3. Time of Death
Physician /Medical	Mario Rodriguez	Septem	ber 8, 1998 12:30 AM
Examiner	4e Fecility Name (If not institution, give street end number)	4b. City, Town, or Location of Dee	
19 L	Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	Bethesda ear If Under 24 Hrs. 8, Date of B	Montgomery
Funeral Director	430-45- 5290 11√2 F 76 Yrs. Months Da	ys Hours Min. (Month, L	Sirth Place (State or Foreign Country) 5, 1922 unknown
and *	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Maryl 1 sho	Maryland Montgomery Bethesda		1 ☐ Yes 2 ☐ No
deeth with the Maryland ms 23s or 28s-f show Imust be notified at ner al Director	10e. Street and Number 10f. Zip Cod	Je	10g. Citizen of What Country?
Man o star		.4	U.S.A.
or he man		of Hispanic Origin? (Specify Yes or N Cuben, Mexican, Puerto Ricen, etc.) No Specify:	No- 14. Rece - American Indien, Black, White, etc. Specify: Hispanic
72 hours "natural",	15. Decedent's Education (Specify only highest grade completed) (Give kind of work de	cupation	16b. Kind of Business/Industry
21215-0 ed within 72 ho ygiena. er than "natur ft, Ita Maxicall Completed	Elementary/Secondary (0-12) College (1-4or 5+)	one during most of working tired)	
7 7 7 7	unknown unknown unknown		unknown
Be ever		18. Mother's Neme (First, Midd unknown	lle, Meiden Surneme)
Maryland 212 d 2 should be filed with th and Mental Hygiena. 7 is marked other than traumatic event, that		reet and Number or Rural Route Num	observation City of Time Code)
2 77 5	19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Strunknown unknown	set end Number of Aurer Abute Num	noer, City or Yown, Stelle, 210 Code)
item 2	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Mother (Specify) in State	f Date	20c. Location - City or Town, State
Baltimo Baparment Page Department Comportant: If Important: If any Inlury or ance.		ore, Maryland 212	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) a. Due to (or es a consequence of):		elog
P.O. BOX 68/60, at the death certificate be assected by the attending physician and elached for use as the burial-transit Physician/Medical Examine		two Pulmon	on men gla
- 00 -			d tobacco use contribute to the cause of death
The law requires the law requires the last been significated by Completed by		24a. Wa	as en autopsy rformed? 24b. Were eutopsy findings available prior to completion of cause of death?
		10] Yes 2/03 No 1 ☐ Yes 2 ☐ No
certificate rector, pag	25. Was cese referred to medical	26. Piece of Deeth (Check only	y one)
- K 95 C	27. Manner of Death 1 Naturel 5 Pending (Month, Dey Year) 28c. 1		esidence 6 Other (Specify) se how injury occurred
To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral Medical Certification:	2 Accident 3 Suicide 4 Homicide Accident ice 28f. Location	n (Street end Number or Rural Route Number, Town, Stete)	
To the Hospital Within 24 hours To the Funeral completaly filled		ny opinion, death occurred et the time	e, date and place, and due to the cause(s)
To the troop of th	I for John M-D D	20516	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tof (Sch 4/m 4n 94/0 0) 6 6 8 7 9 9 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Jona Ad Bet	Leido 140 Log13
State Registrar	SEP 2 3 1998 S. Span	Val	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Peath **Examiner** JOSEPH RICHIE HOSPICE BR/ timore If Under 24 Hrs. 8 Date of Birth Hours Min. Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1□M abT 212-42-72/5 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits BA/HHOK 1ATes 2□No Examiner nast be notified Director /lary/ors 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2502 238 21217 U5A Funeral death v 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give items 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Introductant: If Item 27 is marked other than "natural; or ite any Injury or other traumatic event, the Mental Examine 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify by 3 ☐ Widowed 4 Divorced Specify: Black Year or Dates: Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of Marylans Elementary/Secondary (0-12) College (1-4or 5+) CrEtary 12 to grade 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HARRIS MELINDA ERUIS Compbell 2 19a. Informant's Name/Reletionship (Type, Print), 19b. Mailing Address (Street and Number or Bural Route Number, C 2502 EU THU Place 4400 City or Town, Stete, Zip Code) 200/7 Baltimore DESIREE DAUGHER 2502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burlal 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) MEMONAL lark 22. Name end Address of Facility CUP TAIRY 52 40 REISTERS FOR WE KORN 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ta to bram lung , Liver Cres **Examiner** Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In death) Last and (or es e consequence of) Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? Completed 24a. Wes an autopsy The law page 2 s 1 □ Yes 20 No 1 Yes 20 No Division of Vital or Attending Physician: 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) Ho spice Hospitel: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 5 Pending Investigation Natural 2 Accident death. 1 Yes 2 No within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homlcide Hospital 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es steted.

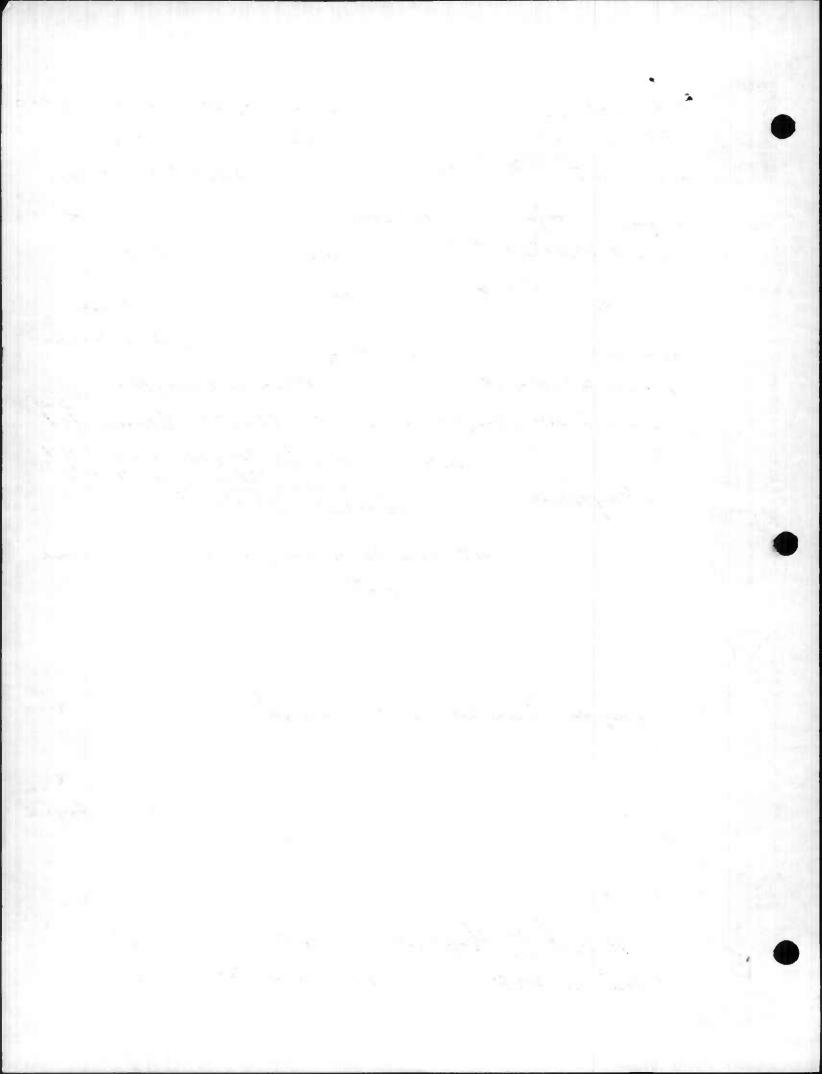
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature end title of certified 29c. License number 29d. Date sigged (Mghth, Day, Year) D 02290 ayes, mi 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Linda Due A1155, MA

32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** REDMOND HNOSELK 0. SEPTEMBER 20 1998 01:02 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CONFUERSITY OF MARYLAND MENICAL CENTER

7. Age (In yrs. last birthday) If Under 1 Year BALTIMORE CITY BALTIMORE If Under 24 Hrs. 8 9. Birthplace (State or Foreign Country)
Maryand 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 2XF Months Min. Days Hours Yrs. Director 219-96-024 JUNE, 17 1968 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits man be notified at 1 Yes 2 No Director N Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6006 Amberwood 21206 items 23s Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stalus r than "naturel", or item the Medical Examiner Black, Whita, atc. 72 hours effer 1 Never Married 2 ☐ Married Baltimore. Maryland 21215-0020 1 Yes 22 No Specify: specify: HFro-American à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nation ping or other treumatic event, the Median page. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home binemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Bernadette Redmond INKNOWN 2 19a. Informant's Name/Ralationship (Type, Print) (SISTER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6006 Amberwood vonne Kedmond Baltimore, Md. 21206 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State Voshell Gardens Dundalk, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens ineral 2222 w. north ave Baltimore, Md. 21216 23a Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Interval Batween Onset and Death **Physician** Immediata Causa (Final disease or condition resulting In death) /Medical SYNDROME Examiner Due to (or as a consequence of): Physician/Medical Examiner NOOCHEDITS Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Bud. Due to (or as a consequence of): 8 Due to (or as a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes END STAGE RENAL DISEASE Records, þ 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? HIERPARATHYROUSEN 1 □ Yes 2 No 1 □ Yes 2 □ No this certificate Division of Vital Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred of a Attending Part of the Court Natural 2 Accident 5 Pending investigation 1 ☐ Yas 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours or To the Funeral Completely filled edical Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and dua to the causa(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and 85e of certifie 29c. License number amijua-2292 SEPTEMBER 20, 1998 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

BALTIMORE

IFE FADEYI, MD. 22 S. GREENE SK.

Registrar's Signature

31. Date filed (Month, Bay Year) 98

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month q James Ross 18 1998 20:46 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death University of Maryland 5. Social Security Number 6. Sex Medical System Baltimore If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Deys 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 1X M 2 F 212-22-1662 MARYLAND Usuel Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE CI Yes 2□No MARYLAND 10e. Street end Number 10g. Citizen of What Country? 2736 AVENUE KINSEY 14. Race - American Indien, Bleck, White, etc. 12/Wes Decedent Ever in U.S. Armed Forces? 1 MYes 2 No 07-30-45 If Yes, Give Yeer or Detes: 11-27-46 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Nevar Merried 2 Merried 1 ☐ Yes 2 🗙 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorcad 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) ROOFING COMPANY SUPERVISOR YNKNOWN 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ROSS MAGGIE EE NATHANIEL 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 2417 WEST PORT STREET, BALTIMORE, MD. 2/230 ca of Disposition (Name of Deta 20c. Location - City or Town, State SISTER SHIRLEY GUEST 20e. Method of Disposition 1. Buriel 2 Cramation 3 Removel from State 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 25-98 OWINGS HILLS, MD. 4 Donetion 5 Other (Specify) GARRISON FOREST 21. Signature of Funeral Service Lice 22. Neme and Address of Fecility. JOSEPH H. BROWN JR. FUWERAL HOME 23a. Perti. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximata Interval Batween Onsat and Deeth Immedieta Causa (Final Cancer Lung 5 years diseese or condition resulting in death) Dua to (or as e consaquence of): Hypertension Pulmonary 3 Years Sequentially list conditions, if any, leeding to Immediata causa. Enter Underlying Ceuse (Disease or injury that initieted events resulting In deeth) Lest Dua to (or es e consequance of): Pulmonale 2 months Cor 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only ona) 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

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Funeral

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permit. Peges 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic avant

the Medical Examiner must be notified at

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Funeral

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Baltimore, Maryland 21215-0020

Examiner Physician/Medicai þ Completed Be

funeral director, Certification:

signed by the after death. Director: Aft ò Hospital 24 hours a Funeral C

Division of Vital Records, P.O.

To the To the F 4+1

Registrar

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29a. Certifier

(Check only one)

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31. Dete filed (Month, Dey, Year)

Pert II. Other eignificent conditions contributing to deeth but not resulting in the undarlying cause given in Pert I. 25. Was case referred to medical exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Spacify) 1 Yes 2 No 27. Manner of Deeth Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide

1 Cartifying Physician: To the best of my knowladga, daath occurred at tha tima, data and place, end due to the ceuse(s) end mannar as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certified

29d. Date signed (Month, Dey, Year)

30. Name and address of person who complated causa of death (Item 23a) (Type, Print) BIRNAUM

GreveSt South 32. Registrer's Signeture souls

Baltome MD 21043

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** James Ripley Sept. 22, 1998 1:00 pm /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** Baltimore Reisterstown Cherrywood Nursing Home 8. Dete of Birth (Month, Dey, Yeer)
July 30, 1910 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Scotland 10**X**M 2□ F Months Deys Hours Min 88 Yrs. 217-01-3681 Director Usuel Residenca of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, Steta 10b. County 1 Yes 2 No Md. Baltimore Reisterstown Director 10g. Citizan of Whet Country? 10e. Street end Number 10f. Zip Code U.S.A. 21136 122 Nicodemus Rd. "natural", or items 23a Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 14. Reca - American Indien, 11. Meritel Stetus Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after of or of or health and Mental Hygiene.
Int: If term 27 is marked other than "netural; or file into or other traumatic svent, the Medical Example. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usa ratired) College (1-4or 5+) Elementery/Secondary (0-12) Steel Worker Bethlehem Steel 18. Mother's Name (First, Middle, Malden Surname) 17. Fether's Neme (First, Middle, Last) Mary Menning Edward Ripley 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 122 Nicodemus Rd., Reisterstown, Md. 21136 James Edward Ripley 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Buriai 2 Cremetion 3 Removel from Stete permit. Page Department of Important: If any Injury or once. Meadowridge Mem. Park Sept. 25, 1998 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md. 23a. Pert I. Enter ID disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or he in Teilure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition rasulting In daath) /Medical Examiner Examiner Y Sequentielly list conditions, if eny, leeding to immediata cause. Entar Underlying Causa (Disaasa or Injury that initieted events resulting in deeth) Lest and physician a s the burlatof Vital Records, P.O. Box 68760, Due to (or es e consequence of): certificate be Physician/Medical 94 Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? B 1 Yee 2 No Probably 4 Unknown pedis d pe de à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy certificate has inector, page 2 2000 Dementha 1 Tyes 25. Wes case referred to medical examiner?
1 ☐ Yes 2 No 88 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 0 1 Inpatiant 2 ER/Outpatient 3 DOA 4 27. Menner of Death 28c. tnjury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred Certification: After Division Attending 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicida 6 Could not be 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29e. Cartifiar edical 29b. Signature and fittle of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Nama end address of person who completed cause of daath (Item 23a) (Type, Print) Releteratown MD21136 Mini Panikas m.12. 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State SEP 2 3 1998 Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** KOGERS Sept SEORGIA 710 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not Institution, give street and number) Examiner BALTIMORE LOSPITAL HGNES If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** 1 M 2 KF Months Days Hours Min Yrs 213-18-4176 Director Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at BALTIMORE 1 Yes 2 No NA Director WV 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21729 USA 830 HUGUSTA Funeral 14. Race - American Indian. 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: P 3 Widowed 4 □ Divorced -AC Completed 16b. Kind of Business/Industry 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 end 2 should be filed within: Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Home 5+h DOMESTIC NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be FIZHER MAGALENEJACK DODDO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Kim JACKSON-GRANddauchter 2938 RD BACTO, MD 21227 BERD other 20b. Placa of Disposition (Name of cametery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriai 2 Cremation 3 Remove from State iny Injury or 9.2698 ARBUTUS MEM. PARK DALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility of Funeral Service Licansee Hong West, INC March Fineral Hong West, Fr. 4300 Wa bash Ave Balto nd tarris 21215 23a. Part. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** HOURS Immediate Cause (Final disease or condition resulting in death) /Medical ASPIRATION PNEURONIA **Examiner** HOURS Examiner CEREBRO VASCULAR ACCIDENT physician and the buriel-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that Initiated events resulting In death) Last Due to (or es a consequence of) DAYS SEIZURES Physician/Medical Due to (or es e consequence of): YEARS 80 PERTENSION 950 signed by the a 23b. Did tobacco use contribute to the cause of death? Part ff. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed' page 2 s 1 □ Yes 2 No 1 Ves 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of tnjury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homictde Dic 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner steled. (Check only one) within 2 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Muero Polloduro MD SEPTEMBER -21-1718

State Registrar 31. Dete fited (Month, Day, Year)

SEP 2 3 1998

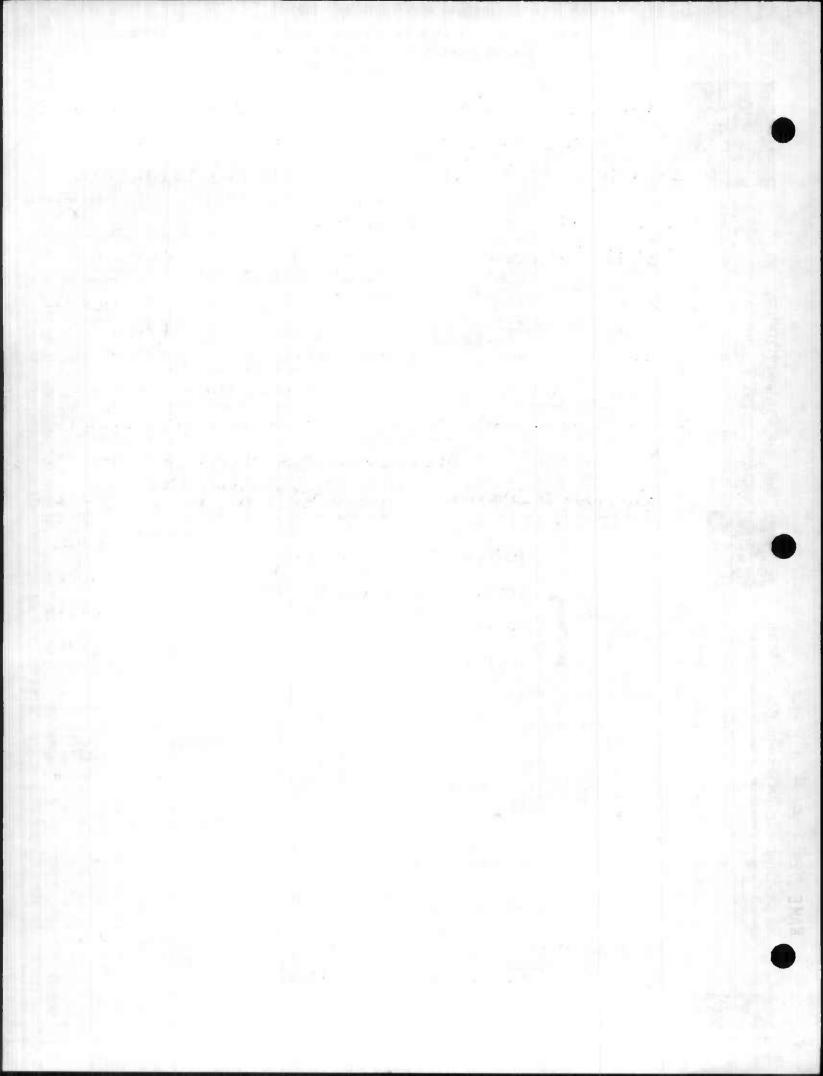
32. Registrar's Signeture

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

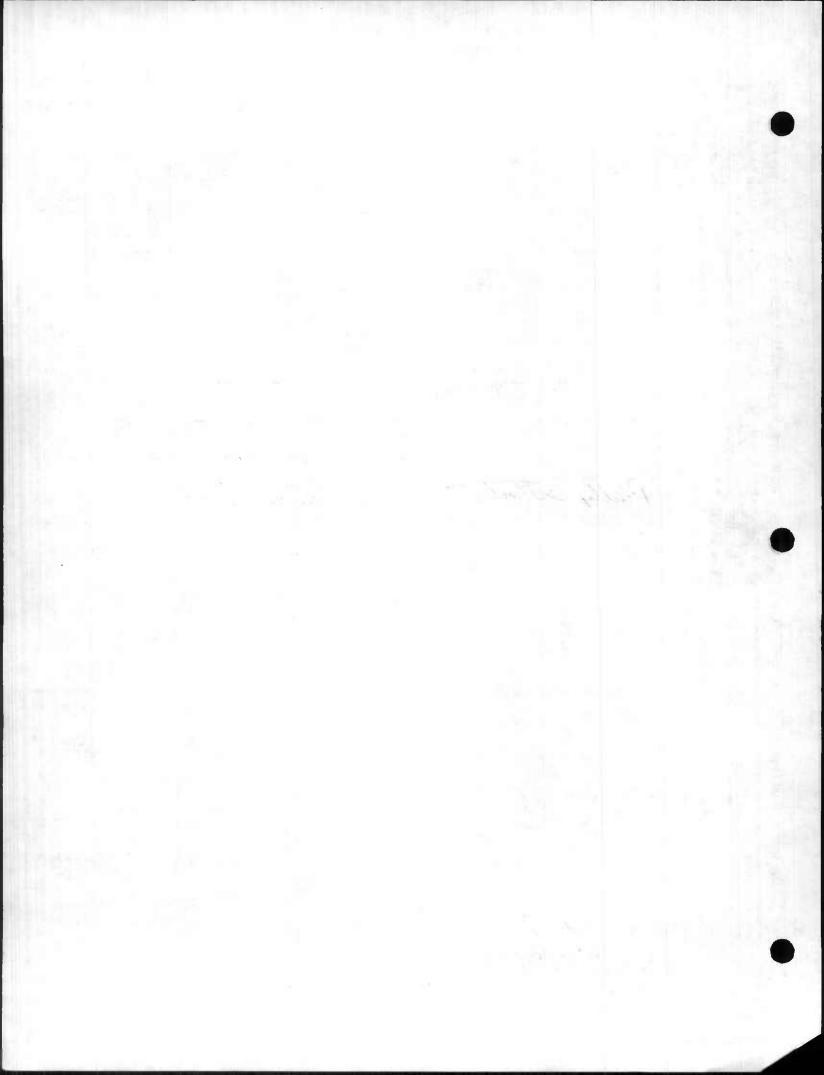
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	State of Maryland / Department of Health and M Certificate of Death	Re	g. No	29202						
Physiciar	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Yea	3. Time of Death						
/Medica	MARGARET MARY ROSENDALE	SEPTEMB	ER 18 199	8 10:20PM						
Examine		cation of Death	4c. County of De	eath						
	6410 ALTAMONT AVENUE CATONSVILI	Œ	BALTI	MORE						
Funeral Director	5. Social Security Number 212-07-0654 6. Sex 1 M 2 F P P P P P P P P P P P P P P P P P P	8. Date of Birth (Month, Day, DEC 2 1	901 9. E	Birthplaca (State or Foreign Country) MD						
yland	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
uth with the Manylan 23a or 28a-f ahow	MD BALTIMORE CATONSVILLE			1 ☐ Yes 2 ☒ No						
vith th		10	g. Citizen of What	Country?						
234 F	6410 ALTAMONT AVENUE 21228	7 1	USA							
72 hours after deeth with the Manyland natural; or items 23s or 28s-f show		Rican, etc.)	Black, W	merican Indian, hite, etc. WHITE						
72 hours	15. Decedent's Education 16a. Decedent's Usual Occupation	1	6b. Kind of Busines	ss/Industry						
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be filed tal Hygin d other event, the		(First, Middle, M	laiden Surname)							
should be and Mental marked o umatic ev	ALOYSIUS H. ROSENDALE HELEN	DOWNE	Y							
Maryland d 2 should be file th end Mental Hy T Is marked oth traumatic event	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	l Route Number,	City or Town, State	a, Zip Code)						
	CARLEEN CROSS, NIECE 115 GLENMORE AVENUE, CA									
S - E 0	20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)	Date 2	0c. Location - City	or Town, State						
timen tent: youry	4 □ Donation 5 □ Other (Specify) NEW CATHEDRAL CEMETERY)/21 I	BALTIMORE	, MARYLAND						
permit. Pege Department o Important: If any Injury or BRGS.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility STERLING ASHTON FUN 736 EDMONDSON AVENUE			21228						
Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one ceuse on each line.			Approximete Interval Between Onset and Death						
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Mys conduct Inforction			1hn						
	Due to (or as a consequence of):									
cate be executed physician and the burial-transit	b. Due to (or as a consequence of): If any, leeding to immediate									
ficate be ex physician as the burial	Ceuse (Disease or injury that initiated events									
7 = = = 0	resulting in death) Last									
at the death certification of by the attending letached for use as Physician Me	d									
the de y the a ached i	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tot	ute to the cause of death?							
	Arth. his	1 Yes 2 No 3 Probably 4 U								
been si should		24a. Was an perform		b. Were autopsy findings available prior to completion of cause of death?						
F ad C		1□ Yes	s 261No	1 ☐ Yes 2 ☐ No						
ysician: The sector, particular director, particular Co. Be Co.	25. Was case referred to medical axaminer? 26. Place of Deeth	(Check only one	9)							
- 5 90		ne 5 Hesider	nce 6 Other (S	pecify)						
After thi funeral funeral		28d. Describe how	w injury occurred							
r Attendent irector: n by the	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (Street and Number or Rural Route Number, City or Town, State)								
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert		and due to the car ad at the time, da	use(s) and menner ite and place, and d	as stated. due to the cause(s)						
Mithin Vithin Somp		29	d. Date signed (Mo	onth, Day, Year)						
-3-19	D344TI		921-	57						
AFTER A	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDMIND PORKWILL MO 405 Fellick RI Su Le 100									
State	31. Uate tiled (Month, Day, Year) 32. Régistrar's Signature									
Registrar	SEP 2 3 1998 . Apartal									



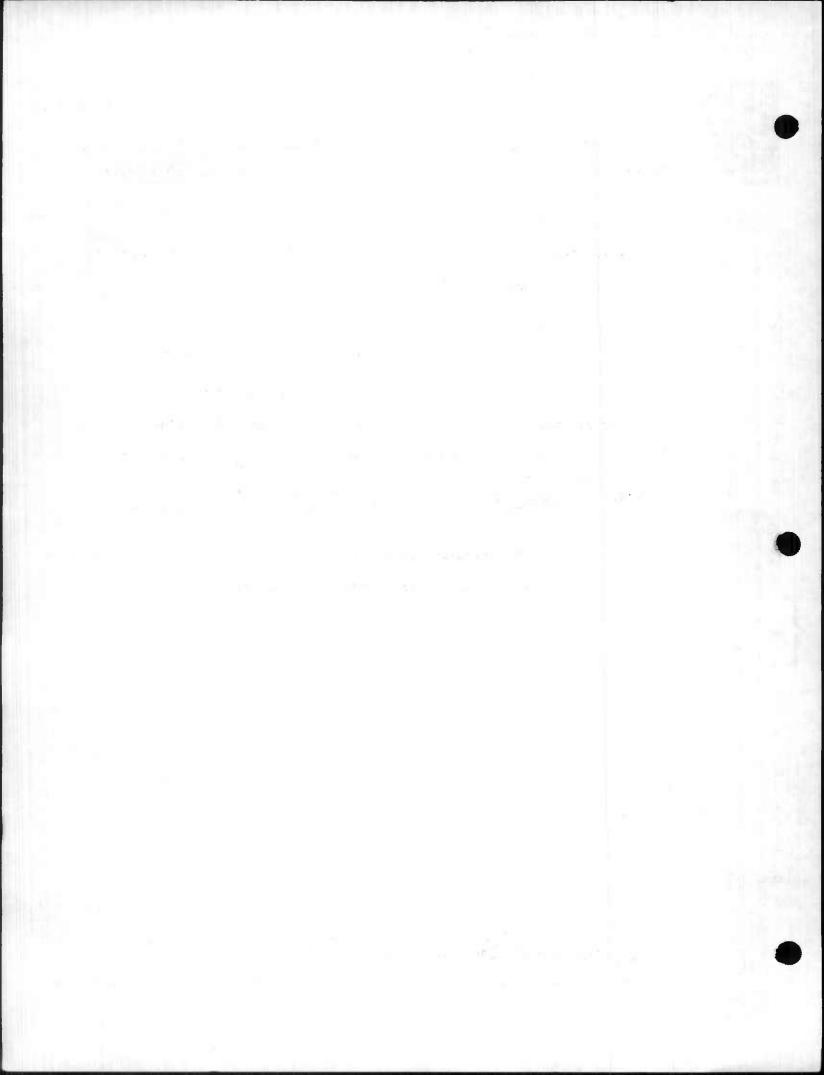
Di di di	1. Decedent's Name (First, Middle, Last)			2. Dete of Death Month	Day Year	3. Time of Death
Physician /Medica	Shirley Myan		5	EFTEMBER		9:50 PM
Examine	4e Facility Name (If not institution, give street and number)		4b. City, Town, or Loc	ation of Death	4c. County of Death	
	Stella Maris Mercy Hospital		Baltimore	City		N/A
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. le	Months Days	r If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye.	9. Birthp	laca (State or Foreign try)
Director	219-32-4477 61	Yrs.		March 24		cyland
2 .	Usuel Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location			1	Od. Inside City Limits
aryla al aryla	Maryland N/A		Baltimore	City		XXYes 2 □ No
vilh the Ma	10e. Street and Number	10f. Zip Code	Dazozmozo	4	0.00	
		Tot. Zip Code	04.004		Citizen of What Coun	
her death v here death v here zan	3211 Esther Place 11 Marital Status 12. Wes Decedent Ever in U.S.	12 Was Doordant of	21224 Hispanic Origin? (Spe		nited Stat	
The Date of	11. Marital Status 12. Wes Decedent Ever in U,S Armed Forces? 1 □ Never Merried 2 ☑ Married 1 □ Yes 2★□ No		ban, Mexican, Puerto F	Rican, etc.)	Black, White,	
7. 88	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ KNO	Specify:		Specify: W	nite
21215-0020 d within 72 hours at plane. The Medical Exam		16a. Decedent's Usual Occi	upation	16b	Kind of Business/Inc	lustry
21215-0 ad within 72 ho systems. we than "neturn it, the Medical.	(Specify only highest grade completed)	(Give kind of work don- life. DO NOT use retir	e during most of working ed)	9		
The line of	Elementery/Secondary (0-12) College (1-4or 5+) 11 Years	Housewife			Own Home	
and the file ontal Hyge and other c event,	17. Father's Name (First, Middle, Last)	1120.7	18. Mother's Name	(First, Middle, Maid	len Sumame)	
Viar vid by Monta	Walter Weaver		Idessa	Blair		
de de la company	19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street	et and Number or Rural	Route Number, Cit	y or Town, State, Zip	Code)
Z 24 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Mr. Andrew F. Ryan (Husband)	3211 Esther	Place Ba	ltimore,	Maryland	21224
L Pages 1.a ment of Her tart: if Nem (ury or othe	00	ace of Disposition (Neme of prefery, cremetory or other pl	lece)	Date 20c.	Location - City or To	wn, Stete
Page 1	1 @Bunai 2 Cremetion 3 C Hemoval from State	Lawn Cemeter		998 B	altimore,	Maryland
S Injury	2 Signature of Funeral Service Licensee /	22. Name and Add	ress of Facility Funeral H	Du	and all In	
0 88558	Add William		Ave. Dun			222
	23a. Part1. Enter the disease, or complications that caused the deeth, shock, or heart failure. List only one ceuse on each line				ylana zi	Approximate Interval Between
Physician	shock, or heart failure. List only one ceuse on each line				1	Interval Between Onset and Death
/Medical	Immediate Cause (Final	mat	1		1	Haraid
Examiner	disease or condition resulting in death)				1	10 month
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secuted al-frensit	Sequentially list conditions Due to (or	as a consequence of):	ung	ar cin	Jomai	I (MONY
Dy exec an an mal-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	as a corresponde ory.	0		1	
98/60	that initiated events	es e consequenca of):				
7 PM 25 " W	resulting in death) Last					
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- 2 4 - 11	Part II. Other significant conditions contributing to death but not result	Iting in the underlying cause g	iven in Part I.	23b. Did tobac	co use contribute to	the cause of death?
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S, that is that is the se ded						
The law requires the law requires the last been signed, page 2 should be completed by				24e. Wes an au		ere autopsy findings allable prior to
law re law re 2 sho				ponomio	CO	mpletion of cause death?
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	axaminer? 1 Yes 2 Hospitel: 1 Inpatient 2 E	R/Outpatient 3 DOA	ther:	e 5 ☐ Residence		HOOPice
g Physics er this seral d		28b. Time of lnjury 28c. Inj	ury at 2	8d. Describe how is	njury occurred	
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OIVISION or Attending after death. Director: After in by the func	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office	9 2	8f. Location (Street City or Town, St	and Number or Rura	t Route Number,
DIVISION C ball or Attending P is after death. at Director: After t ed in by the funera Certification:	building, etc. (opecity)			ony or round or	410)	
Hospital or 24 hours afte Funeral Directle in etely filled in	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination	riedge, death occurred et the	time, date and place, e	nd due to the ceuse	e(s) and menner as s	ated.
To the Hospital within 24 hours a To the Funeral I completely filled	(Check only one) 2 Medical Examiner: On the basis of examination end manner steled.	on endor investigation, in my	opinion, death occurre	u at the time, dete	and place, and due to	ure CaUSO(S)
To the comple	29b. Signature and title of certifier	UCUX 29c. Licer	nse number	29d.	Date signed (Month,	Day, Year)
	16/10/ Mon m		07930	bx	tembor	21.1998
12	30. Name and address of person who completed cause of death (Item.	23a) (Type, Print)	1 C+ Ra	118/2	0)1.0
10	Marvin J. Feldman	Mn D	a I tim	080 V	hd. 21	202
State	31. Date filed (Month, Day, Year) 32, Registrer's Signett	ure				
Registrar	3 1998 Sheer	h 1.				
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Seila Whale was issued

State of Maryland / Department of Health and Mental Hygiene 99999

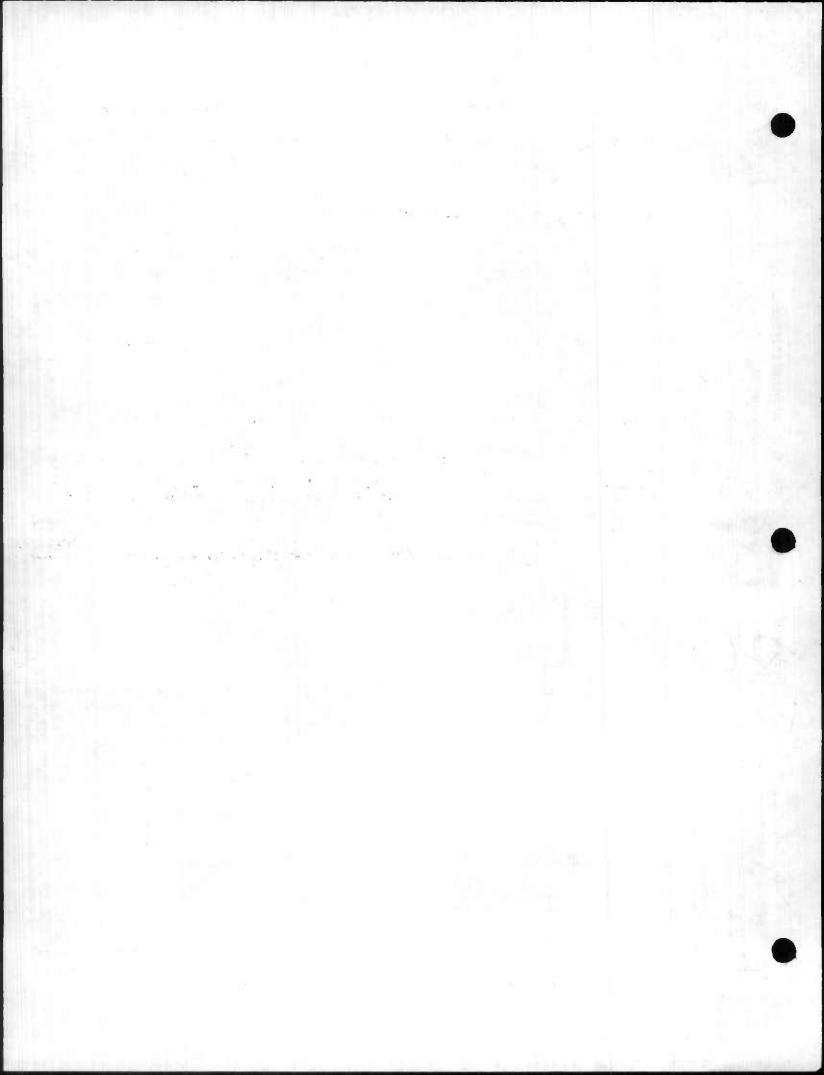
					Certifica	ate of	Death		Reg. No.	-	1204
Physic	ian	1. Decedent's Neme (First, Middle, Last Marlin G. Safi						2. Date of D	ber 19,		3. Time of Death LO:39 AM
/Medi Examii		4e. Facility Name (If not institution, give					4b. City. Town, or				10:39 AM
Funeral Director	lei	North Arundel Ho 5. Sociel Security Number 6. S	ospital ex 7. Age	(In yrs. last bird	thday) If Und Month	ler 1 Year s Days		rnie 8. Date of B (Month D May 2)	Ann	e Arund	del e (State or Foreign nd
pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	o or Leasting					Teat	
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the A	Director	10e. Street end Number	unger	56		ip Code			10g. Citizen of		
h with	ai Di	1349 Brenda Road	E				21144		United		
permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Depertment of Health end Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Maritel Status 1 □ Never Married	12. Was Decedent Ev Armed Forces? 14 Yes 2 □ No It Yes, Give Year or Dates:	19/12-			Hispanic Origin? (Seen, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	14. Rac Ble Specif	ca - American I ck, White, etc. y: Whit	
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end 2 salth er n 27 is		Jean M. Safely/Wi					Rd. Sev		21144	, 0,410, 2,000	56)
Pages 1 e		20e. Method of Disposition XXSunal 2 □ Cremation 3 □ 4 □ tonation 5 □ Other (Specify		20b. Placa of cemeter	Disposition (Ny, crematory of Ville V	ame of other pla	ice) Sen	Date t. 22,	20c. Location		
permit. Depertri		21. Signature of Funeral Service Control Serv	ul	he death. Do n	Kirkle	y-Ru ain	ess of Facility ddick Fur Hwy S.E Ing, such as cardia	Glen F	urnie.	Ap	proximate erval Between
Physician /Medicai Examiner		Immediate Cause (Final disease or condition resulting in death) Ventricular Fibrillation Immediate Immediate Cause (Final disease or condition resulting in death)									
	je l			Sclero		,	Vascular	Disease		Ve	ears
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es thet the de igned by the a be deteched	Physician/N	Part II. Other significant conditions co Hypertension	ntributing to death but	not resulting in	the underlying	cause gi	ven in Part I.				e cause of death ly 4 Unknow
requires been sign should be	Completed by							24a. Was	an autopsy ormed?	evallat	autopsy tindings ble prior to etion of cause th?
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by est	Certification:	2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, Stete)			
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To th To th comp	Me	29b. Signature and title of certifier	n P. Don	mul		9c. Licen: D23	se number 811		29d. Date signe Septembe		
10		30. Name and address of person who co Jonathan P. Forem	ompleted cause ot dea	ith (Item 23a) (Type, Print)	n Hw	y. Glen H	Burnie,	MD 2106	l Suite	304
Sta Registr		31. Date tiled (Month, Pay Year) 199	8 32. Registrar	s Signature	4 1	,					



State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middia, Las.		Reg. No. 2. Data of Death 3. Time of Death							
Physician	TOA	STEE	15			Month SENTE	Day 21	2/95 65T		
/Medical Examiner	4a Facility Nama (If not institution, giva	r Location of Dea		of Death Pri						
Examine	HONTHWEST !	HOSPITAL	Con	TER	PANDA	MS Town	N BA	Timore		
Funeral Director	5. Social Sacurity Number 6. Se	7. Aga (In yrs. last birtho 80 Yr	Months D	ear If Under 24 Hi ays Hours Mi	n. 8. Deta of Bi (Month, D NOV.	rth ay, Year) 26,1917	9. Birthplace (Steta or Fora Country) Maryland		
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with the Maryland a or 28a-f show Lba.notified.at	10a. Stete 10b. County Marvland Carroll		0c. City, Town of Syke	sville				10d. Inside City Limi		
or 28a-f a ba notifies Director	10e. Street and Number			10f. Zip Co	rie		10g. Citizen of W	That Country?		
er death with the Maryles thems 23e or 28e-f show one must be notified at uneral Director	931 Fannie Dorsey	Rd.		217	84		United S			
Examination by F	11. Meritel Stetus 1 Nevar Married 2 Married 3 Wildowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Give Yaar or Datas:	er in U,S.		of Hispanic Origin? Cuban, Mexican, Pue No Specify:	(Specify Yes or Nerto Rican, etc.)	0- 14. Race Blace Specify:	e - American Indien, k, Whita, atc. White		
natural region of 72 ho	15. Decedent's Edu		16a. D	ecedent's Usual O	ccupation	and in a	16b. Kind of Bu	siness/Industry		
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ygiene. Ygiene. Ye the Man	Homemaker									
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and 2 s satth an n 27 la r ar traur	19a. Informent's Name/Ralationship (T) Carol E. Dick / D		le, MD 2							
Pages 1 ment of H ant: if hen ury or oth						Sept. 23,1998				
Departi Departi Import any inj 2008	21. Signedure of Fortural Sarvice Licens	عال			ddress of Facility Ruddlck F n Hwy., S			, MD 21061		
Physician /Medical Examiner	Immediata Cause (Final disease or condition rasulting In death) CHRONIC OBSTRUCTIVE PULLWONARY DISEASE YEAR Due to (or as a consequence of):									
an and utal-trainsit	Sequentially list conditions, if any, laading to immadiate causa. Entar Undertying Cause (Disaase or injury c.									
Medica	that initiated evants rasulting In death) Last Due to (or es e consequence of):									
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and the deaponder of by the attending detached for use	Part II. Other algniticant conditions col		23b. Did tobecco use contribute to the cause of dea							
The law requires the cate has been signed page 2 should be d						24a. Wa	s an autopsy ormed?	24b. Were autopsy tinding available prior to completion of cause of death?		
The law ats has page 2						10	Yas 2 No	1 ☐ Yes 2 ☐ No		
certificate rector, pa	25. Wes casa rafarred to medical				26. Place of D	eeth (Check only	one)			
Thyaician: this cartific ral director, To Be	examinar?	Hospital: 1 Inpatient	2 ER/Outpi	itient 3 DOA	Other: 4 Nursing	Homa 5 ☐ Res	idence 6 Othe	ar (Specify)		
ath. r: After the funeral e funeral	27. Manner of Death 11. Netural 5 Pending 2 Accident invastigation	a of 28c.	28c. Injury at Work? 1 Yes 2 No			ed				
plial or Attending P ours after death. aral Director: After I filled in by the funeral if Certification:	3 Suicida 4 Homlcida 6 Could not be datarmined	28f. Location City or To	(Street and Number own, Stete)	er or Rural Route Number,						
To the Hospital of within 24 hours at To the Funeral Occupiesely filled		alcien: To the best of niner: On the basis of ex	amination and/o					nner as stated. and due to the cause(s)		
N Ne	29b. Signature end titla of certifier	1 0			cense number		the state of the s	(Month, Day, Year)		
- 3 - 0) (/	mu/S		7	19502		Sep Tom	Bee 20,1991		
20	30. Name end address of person who co	ompleted causa of deat	h (Item 23a) (Ty	pe, Print)	Non	LTHULES	- HEL	DOR 20,1998 PITAL CONTE 7/133		
		3. CONAL		as	A	7				
	31. Data filed (Month Pay, Year)	se contra	was .	20	14NDAM	STONN.	ded.	7/133		

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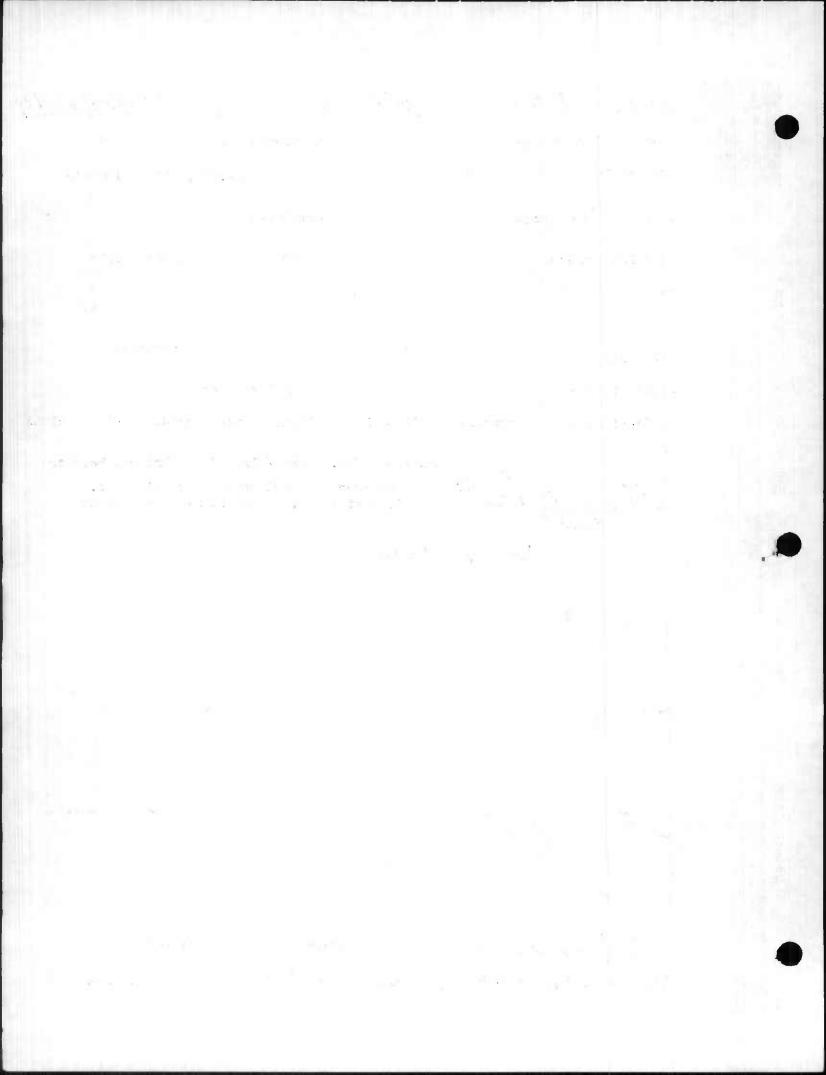
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				Certifica	ile oi	Dealli		Reg. No.		
	1. Decedent's Name (First, Middle, Last)	100				2. Date of D	Death Dey	Year	3. Time of Death
Physician (Madical	Louella Flore		mber 20,		17:45 PM					
/Medical Examiner	la Facility Name (If not institution, give					4b. City, Town	, or Location of Dec			273-12-22
	St. Agnes Hospit	al				Balt	imore			
neral	S. Social Security Number 6. Se	x 7. Age /	In yrs. last birth	day) If Under	er 1 Year Days	If Under 24 Hours	Hrs. 8. Dete of E	Birth Day Year)	9. Birthple	ace (Stete or Foreign
rector	213-16-9331	JM 2□XF	79 Yr	rs.	Days	Tiours	Dec. 2	22, 1918	Count	Md.
	Usual Residence of Decedent								140	
T I	10e. State 10b. County	1	Oc. City, Town	or Location					10	od. Inside City Limits 1 ☐ Yes 2 No
ct o	Md. Baltimo	re	Reis	tersto						
Dir	10e. Street and Number			10f. Z	ip Code			10g. Citizen of		try?
1 E	20 Greenview Ave	.=				21136			S.A.	
and and	11. Maritel Status	Was Decedent Ev Armed Forces?	er in U,S.	13. Wes Dec	edent of F ecify Cub	łispanic Origin en, Mexican, P	? (Specify Yes or I uerto Rican, etc.)	No- 14. Rad Ble	ce - America ck, White, e	
t, the Medical Examiner must be notified Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:		1 ☐ Yes	2 X No	Specify:		Specif	. Whi	te
P P	15. Decedent's Edu	ication	16a. D	Decedent's Us	uel Occup	pation		16b. Kind of B		
plet	(Specify only highest gred	le completed)		Give kind of w life. DO NOT	vork done use retire	during most of d)	f working			
Om	Elementary/Secondery (0-12)	College (1-4or 5+)		upervi	sor			Food S	Service	ce
Be C	17. Fether's Name (First, Middle, Last)					18. Mother's	Name (First, Midd	lle, Meiden Sumen	ne)	
ToB	H. Walters Miller			M. Lippy						
mportain: It is market outer that matural, or listing can or carry and any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informent's Name/Reletionship (T		19b. I	Mailing Addre	ss (Street	end Number o	or Rurel Route Nun	nber, City or Town	State, Zip	Code)
- tra	Patricia A. Sande	rs Daught	er 444	08 Sil	verb	cook La	ne, Owing	gs Mills	, Md.	21117
ette 2	20a. Method of Disposition		20b. Placa of D	Disposition (No., cremetory or	eme of	ce)	Date	20c. Location	City or To	wn, State
7 04	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,		Carrol				9/23/9	8 Hampste	ead. N	Md.
프	21. Signature of Funeral Service Licens		COLLOI			ess of Facility		-		
any Ir	1 Her	50.			-	1 11		4 Reister	cstown	n Ka.
	23a. Pent1. Enter the disease or composhock, or heart failure. List only of	lications that caused th	se death. Do no	Line .	rune:	ral Hom	e Reis	terstown	, Md.	21136 Approximete
	shock, or heart failure. List only of	ne ceuse on each line.					,		1	Interval Between Onset end Deeth
ician dical	Immediate Cause (Final									
Acres 1	disease or condition resulting in death)	8	SEPSIS							2_Weeks
ē		D	ue to (or as a co	onsequenca of	t):				i	
Examiner		b	URINARY			ECTION				2 Weeks
Exa	Sequentially list conditions, if any, leading to immediate	Di	ue to (or es e co	onsequence of	1):				1	
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events	c	ue to (or as a co	annanuanaa af	۸.				-	
Medical	resulting in death) Last		10 (0) 43 4 00	macquerios or	7.				ę	
		d								
ysiclar/	Part It. Other significant conditions co	otributing to death but	not resulting to t	the underlying	1 cause di	ven in Pert I	23h D	id tobacco use co	ntribute to	the cause of death?
Physiclan/					, wase gi	JI HI VIII.		Yes 20 No	3 □ Prot	
be deta		hronic Ren		7.00	0_1.00					
should be detached for leted by Physicia								es an autopsy		ere autopsy findings
	<i>P</i>	bdominal A	ortic A	neurys	m		pe	rformed?	cor	ailable prior to mpletion of cause death?
ge 2							10	Yes 2□No		Yes 2□ No
e C	OF Was once referred to medical					00 81	(David (D)	1		162 5 140
rector, page 2	25. Wes case referred to medical examiner?	Hospital:	0	antiont of	Oti Oti	har:	Deeth (Check on)		has /Cassil	
funeral dire	1 Yes No	28e. Date of Injury	28b. Tir		DUA	4 LI Nursi	Ing Home 5 Re	e how injury occu		y)
fune for	Natural 5 Pending	(Month, Dey 1		jury M	28c. Inju Wo	rk? Yes 2 □ No		,,		
led in by the funera	3 Suicide 6 Could not be	28e. Placa of Injun	/ - At home, fam					(Street and Num.	ber or Rura	I Route Number,
ert.	4 ☐ Homicide determined	building, etc.	(Specify)	.,	.,,			Town, Stete)		
8 0	29a. Certifier 12 Certifying Phy	alcian: To the best of	my knowledge.	death occurre	d at the ti	me. date and r	plece, end due to ti	ne cause(s) and m	enner es st	tated.
4 6		ner: On the basis of e	xaminetion and/							
dical				2	9c. Licens	se number		29d. Date signe	ed (Month, i	Dey, Year)
Medical	29b. Signature and title of cartifier							1		
completaly fi	29b. Signature and title of cartifler	noting	mi							
Tota com	29b. Signature and title of cartifier Government of the cartifier of	rotton,	molo) Prince Briefs	DO	8949		Septem	ber 2	1, 1998

THE LOCAL CONTRACT CONTRACT CONTRACT CONTRACT. England Co. St. Ward

State of Maryland / Department of Health and Mental Hygiene

			Certifica	ate of Death	R	leg. No.	20201
hysician	1. Decordent's Nama (First, Middla, Las	.0U15	SHER	OW	2. Data of Daa	97/0	998 1003H
/Medical Examiner	4a. Facility Nama (If not institution, give	a street and numbar)	011011	4b. City, Town, o	r Location of Daeth	4c. County o	of Deeth
	Joseph Richey Ho	ospice		Baltimo			N/A
neral ector	5. Social Sacurity Number 6. S 213-36-6370 Usual Residence of Decedant	ax 7. Aga (In yrs 60	(s. last birthday) If Un Yrs. Month	dar 1 Year If Under 24 Hr ns Deys Hours Mir		Year) ,1937	Birthplaca (State or Foraig Country) Virginia
Examiner must be notitied at by Funeral Director	10a. Stete 10b. County	10c. C	ity, Town or Location				10d. Insida City Limits
İ	Maryland Balt	imore		Fort How	ard		1 ☐ Yas 2 🎇 No
al Director		9	10f.	Zip Code 21052		Og. Citizan of Wi	hat Country? States
by Funeral	3 ☐ Widowed 4 ☐ Divorcad	12. Was Dacadent Ever in I Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas:		cedant of Hispanic Origin? (pecify Cuben, Maxican, Pua	Specify Yas or No- irto Rican, atc.)	14. Raca	- American Indian, , Whita, atc.
te d	15. Decadant's Ed	ucation	16a. Dacadent's U	sual Occupation	add a	16b. Kind of Bus	
Completed	(Specify only highast gra	Collage (1-4or 5+)	Clerk	work dona during most of w Tusa retired)	orking	Hospi	ta1
e e	17. Fathar's Nama (First, Middle, Last)			18. Mother's N	ema (First, Middle, I	<i>Vlaidan Sumeme</i>)
To	Claude Sherow			Lucil	le Ewing		
	19a. Informant's Name/Raiationship (1	Type, Print)	19b. Mailing Addra	ass (Street and Number or I	Rurel Routa Number	City or Town, S	Steta, Zip Coda)
	Maryann Dodge	(Cousin)		esnut Avenue	Fort Ho	ward, Ma	aryland 2105
	20a. Mathod of Disposition 1 ☑ Buriel 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removel from Steta	Piaca of Disposition (for camatary, cramatory of cadowridge)	vame of ir othar placa) Mem. Park 9/	1		city or Town, Stata
- SUCE	21. Signatura of Furierel Sarvica Lican		22. Nama Duda-	and Addrass of Facility -Ruck Funeral Wise Ave. D	Home of	Dundalk	-
n al er	23a. Peri 1. Entar tha di sa, or comishock, or haart fail . List of ly disassa or condition resulting in death)	a Laryngel	(or as a consequence of		,		Approximete Intarval Between Onset and Daath
i Examiner	Sequentially list conditions, if any, laading to immediate causa. Enter Undarlying Causa, (Disaasa or injury	b. Due to (or as a consequanca o	rf):			
/Medical Examin	that initiated avents resulting in daath) Lest	Dua to (or as e consequance o	f):			
cian							1
Physician/	Pert II. Other eignificant conditions co	entributing to death but not re-	sulting In tha undarlying	g ceusa givan in Part i.			ribute to the cause of death 3 Probably 4 Unknow
Completed by					24e. Wes a perform		24b. Wara autopsy findings aveilebla prior to complation of cause
Somp					1 □ Ya	as 2 No	of daath? 1 ☐ Yas 2 ☐ No
Be	25. Was case refarred to medical axaminar?			28. Place of De	eath (Check only on	a)	
cation: To Be Comp	1 ☐ Yes 2 ☑ No		☐ ER/Outpetient 3☐	DOA Othar: 4 Nursing	Homa 5 ☐ Reside	enca 6 Dothar	(Specify) HOSPICE
Certification:	27. Manner of Daath 1 Matural 5 Panding 2 Accident Invastigation		a of Injury onth, Day Year) 28b. Tima of Injury M 28c. Injury at Work? 1 □ Yas 2 □ No				d
Certifi	3 ☐ Sulcida 6 ☐ Couid not be datarmined	28a. Place of Injury - At h building, atc. (Speci	nome, farm, streat, fact	ory, office	28f. Location (St City or Town		r or Rural Route Number,
edical	29a. Certifiar 1 Certifying Phy (Check only one) 2 Medical Exam	valcian: To the best of my known iner: On the basis of examination and manner stated.	owledga, daath occurra ati <i>on</i> and/or investigati	ad et tha tima, data and piacon, in my opinion, death occ	ce, end dua to tha ca curred et tha tima, d	ausa(s) and mani ata and place, ar	ner as steted. nd due to tha cause(s)
× ×	29b. Signatura end title of certifiar		4	9c. License number	2	9d. Data signad	(Month, Day, Year)
	> Oy/ W.	Wilsonma		7041476	C	09.18.98	
	30. Name and address of person who of RAYMIND W. W.		m 23e) (Type, Print) 65 65 N. CL	arles St. \$416	Belt, mare	E WD.	21264
State	31. Data filad (Month, Dey, Yaer)	32. Registrar's Sign		1			



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** Shetrone 12-05AM Margaret Μ. SEPTEMBER 22ND 1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deat 4e Fecility Neme (If not institution, give street end number) Examiner ARUNDEL NORTH HNNE If Under 1 Year If Under 24 Hrs. RUNDEL BURNIE HOSTITAL 8. Dete of Birth Birthplace (State or Foreign Country) 5. Scolel Security Number 7. Age (In yrs. lest birthday) **Euneral** Deys Hours 1□ M 2 F Vrs 78 220-01-6349 Maryland **Director** Usual Residence of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Anne Arundel Pasadena Director Maryland 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21122 1817 Cremen Road USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Status 1 Yes 2 No If Yas, Give X Year or Dates: 1 Never Merried 2 Married Specify: White 1 ☐ Yes 2 ☐ No þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Etementary/Secondary (0-12) Cotlege (1-4or 5+) Housewife Household 12 18. Mother's Name (First, Middle, Maidan Sumeme) 17. Fether's Neme (First, Middle, Last) Howard Leo McNell v Margaret Schmidt 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 1817 Cremen Road Pasadena Maryland 21122 Bruce Shetrone / son 20b. Place of Disposition (Neme of cemetary, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removet from State 9/25/98 Crownsville, Maryland Maryland Veterans Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena Maryland 21122 sed the deeth. Do not enter the mode of dying, such Intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Finel disease or condition rasulting in daath) 6 W FEICS CARCINDMA STOMACH **Examiner** Due to (or es e consequence of): 5 DAYSI FEBRILE NEUTRO DENIA Examir Sequentially list conditions, if eny, leading to immediate cause. Entar Undarfying Cause (Disaese or injury that initiated events resulting in deeth) Lest Due to (or es e consequance of) edical Due to (or es e consequence of): Physician/M 23b. Did tobacco use contribute to the cause of death? Pert II, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailabla prior to completion of cause of daeth? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 2E No 25. Wes cese referred to medicel exeminer? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Inpatiant 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Daeth 28d. Describe how injury occurred 28c. Injury et Work? Certification: 5 Pending Invastigation 2 No 1 ☐ Yes 2 Accident 6 Could not ba datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Sulcide 28a. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 ☐ Homleida 1 Certifying Physician: To tha best of my knowledga, daeth occurred et the time, dete end plece, end dua to the causa(s) and mannar as statad edical 29a. Certifier 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred et tha time, dete end piece, and dua to the ceuse(s) end menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifing DOCTOR SEPTEMBER 72ND 1998 MEDICAL 00052277 30. Name end eddress of person who completed cause of death (Itam 23a) (Type, Print) NORTH BELLNOEL HOSPITAL MAKYLAND FRANCIS KNASHIE STILOUBE 31. Dete filed (Month Pay 2 3 1998 32. Régistrer's Signature State

Registrar **DHMH 16 Rev 6/95**

item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at

12 should be filed w n and Mental Hygier Is marked other th

Department of Health Important: If item 27

Box 68760

Division of Vital Records,

2

after death Director:

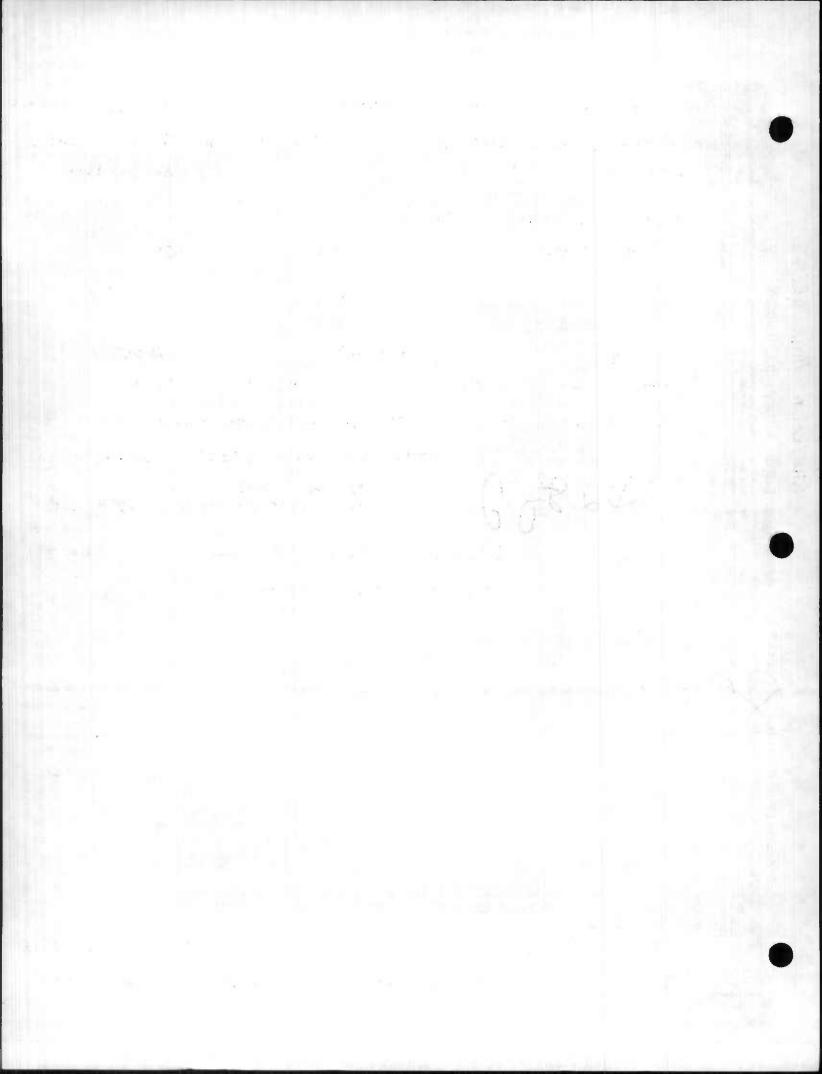
within 2 To the

or Attending

Hospital 24 hours

98 88

SHETKONE, MARCARET



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Year **Physician** PRESTON JAMES SHUMWAY, JR. 0015 1998 /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner CAMBRIDGE DORCHESTER GENERAL HOSPITAL DORCHESTER If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex ★ M 2□ F 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 44 Yrs. 212-62-7269 Director Aug 20, 1954 Maryland Usuei Residence of Decedent flied within 72 hours efter deeth with the Maryland Hygiene. 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits y 28a-f show Maryland Baltimore 1 ☐ Yes 2 No Parkville Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 9237 Smith Avenue 21234 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No if Yes, Give Yeer or Detes: 7 is marked other than "natural", or items traumatic event, the Marical Examiner ms 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritai Status Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Home Improvement Self Employed 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Peges 1 and 2 should be fill ment of Heelth end Mental Hant: if item 27 is marked oth jury or other traumstic even Be Preston James Shumway, Sr. Leatrice Lorraine 19a. Informant'e Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Preston J. Shumway, Sr. 9237 Smith Avenue, Baltimore, Maryland 21234 of Disposition (Name of Date 20c. Location - City or Town, State 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) Buriel 2 Cremetion 3 Removel from Stete permit. Pege Department of Gardens of Faith Cemetery9 23 98 Overlea, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fundad Service Literate

Martin D. Laws 22. Name end Address of Fecility Lauson Altenburg Funeral Home, P.A. 6009 Harford Road, Baltimore, Maryland 21214 Lawson 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximeta Intervai Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel min disease or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): edical Due to (or es e consequence of) Division of Vital Records, P.O. Box Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Wes en autopsy performed? completion of cause of death? ate has pege 2 s 2 NO certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO Yes 2 No #SER/Outpetient 3□ DOA 2 1 Inpatient this funeral (28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? After 1 Maturai 5 Pending deeth. 1 Yes 2 No 2 ☐ Accident investigation after deeth Director: 6 Could not ba datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral C Hospital edical 29a. Certifier 1 Certifying Physician: To the bast of my knowledga, daath occurred at tha time, date end place, and due to the ceuse(s) and menner as stated. completely (Check only one) 2. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the causa(s) end menner stated. To the To the To the F 29b. Signeture end title of certifier 29c. License numbar 29d. Deta signed (Month, Day, Year) 30. Neme and eddr ess of person who completed cause of geath (Item 23e) (Type, Print) 302 Collins NR Herlak Actolon ichne 31. Dete filed (Month, Day, Year) SEP 2 3 1998

32. Registrer's Signeture

Registrar

State

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** C. STARKEY September 20, 1998 4b. City, Town, or Location of Death 4c. County of Death 9:40PM /Medical 4e Fecility Neme (If not institution, give street and number) Examiner EDENWALD Baltimore County 9. Birthpiece (State or Foreign Country) Towson If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. lest birthdev) 6. Sex **Funeral** Deys Hours 1□M 2K) F Months 216-28-7752 96 Director Dec 18, 1901 Maryland Usuei Residence of Decedent with the Maryland 10c. City. Town or Location 10d, Inside City Limits 10b. County item 27 is marked other than "naturel", or items 23s or 28s-f show other traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore County Directo Towson 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 800 Southerly Road permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiena. In the 27 is marked other than "natural", or have any injury or other traument. 21286 Funeral IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Bleck, White, etc. 1 Yes 2 No 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: by White 3 Widowed 4 □ Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Richard A. Chenowith Ida L. MacLeland 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) M. Lee Starkey (Son) 20b. Place of Disposhion Residence Road, Baltaimore 20c Mary Land 221212 20e. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremetion 3 Remove from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Woodlawn Cemetery 22. Name and Address of Fecility 9/23/98 Woodlawn, Maryland pt Funeral Service Lidense Carter O Mitchell-Wiedefeld Home Mart In D. Lewson 6500 York Road, Baltimore, Maryland 21212 23a. Pertt. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate shock, or heart failure. List only one cause on each line. Intervel Between Onset and Deeth **Physician** tmmediete Ceuse (Finel diseese or condition resulting in deeth) /Medical reumona Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medical Due to (or es e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 100 3 Probably 4 Unknown py 2 24b. Were eutopsy findings eveilebte prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? 21 X No 1 Tes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical exeminer? 28. Place of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 216 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 14 27. Menner of Death 28a. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Neturet 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

Division of Vital Records, P.O. Hospital or Attending P 24 hours after death.
 Funeral Director: After 1 24 hours a Funeral To the within 2 To the

Baltimore, Maryland 21215-0020

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check on one)

29a. Certifier

29c. License number

29d. Date signed, (Month, Dey, Yeer) 98

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

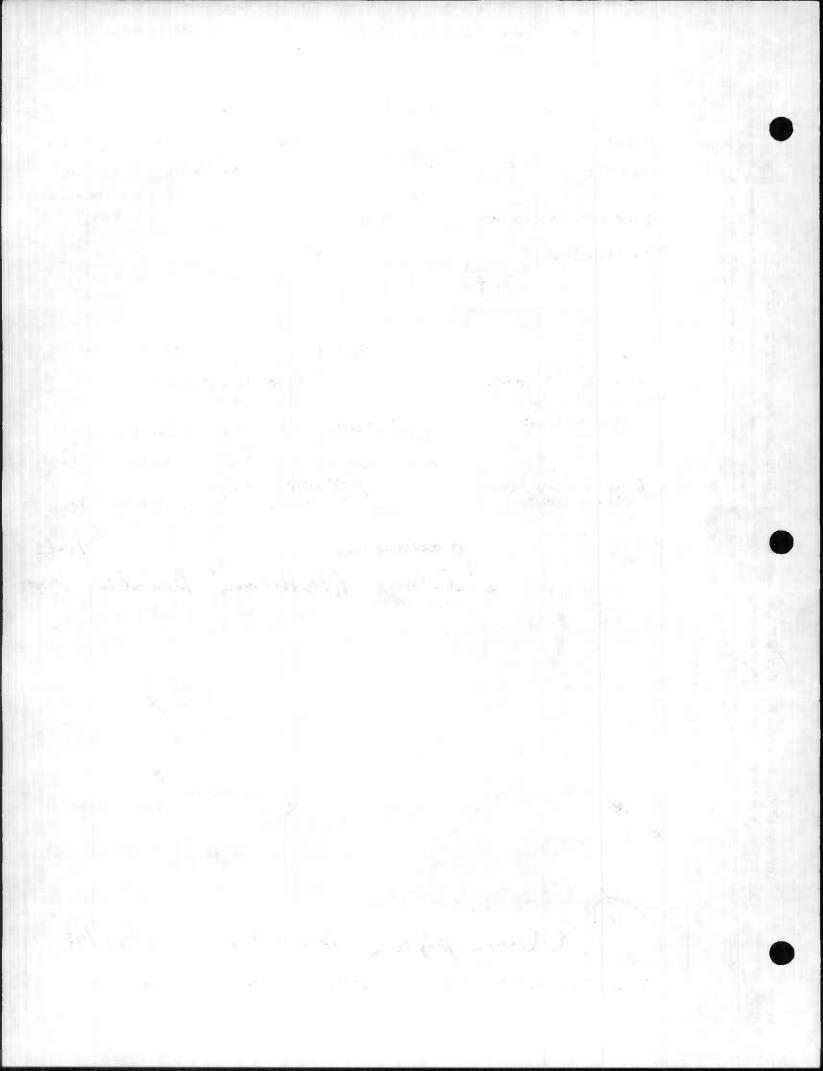
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32. Registrer's Signature MARCELINO D. ALBUERNE 800 31. Dete filed (Month, Dey, Year) SEP 2 3 1998

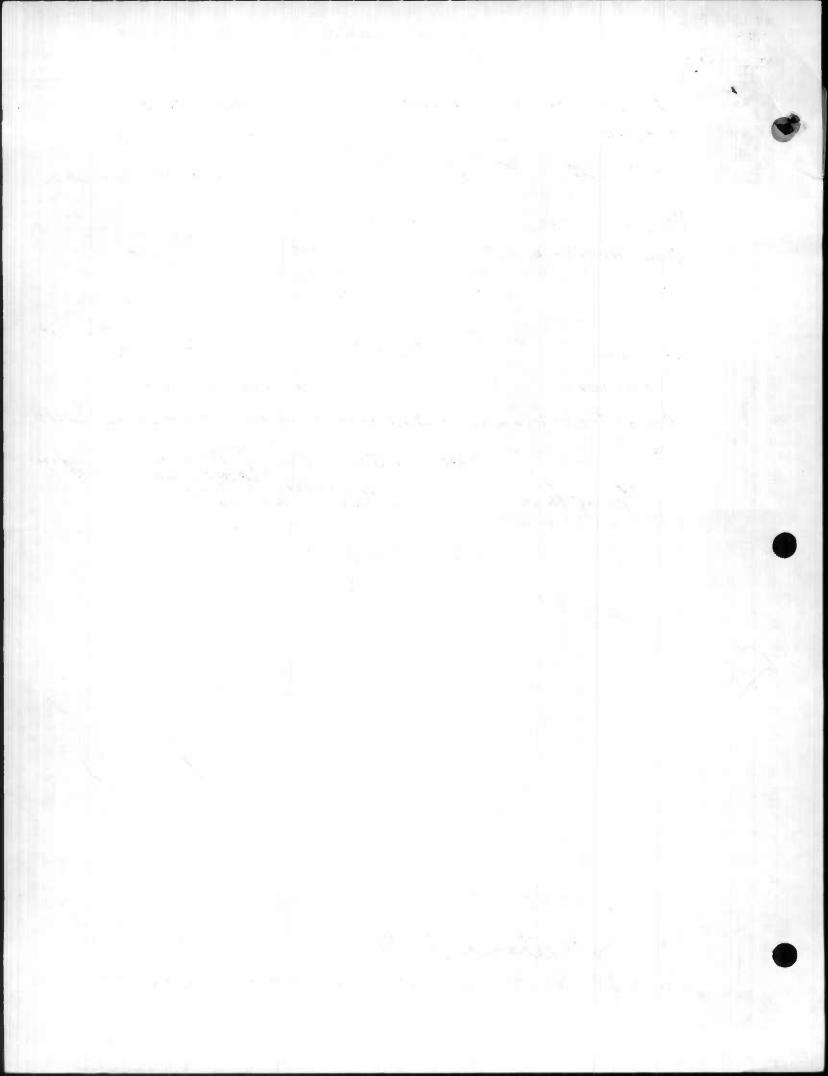
Southerly Road, Towson, Maryland 21204

Registrar



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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Tanner Helen Dorothy September 18, 1998 1:07 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Stella Maris Hospice Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 215-52-2550 Director April 18,1914 Washington, D.C 84 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Dundalk 1 ☐ Yes 2 ☐ KNo Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 8132 Cornwall Road United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: White à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 11 Years College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Andreski Harry Tonneman 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7307 Manchester Road Dundalk, Maryland 21222 Mr. James R. Tanner/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X⊠ Burial 2 ☐ Cremetion 3 ☐ Removal from State Gardens of Faith Cemetery 9/21/1998 Rossville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Puneral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Breast Cancer Examiner Due to (or as a consequence of): Liver Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

pue 68760 Box (Division of Vital Records, P.O. eus signed by t page 2 s hes certificate Attending Physician: Certification: To this After death. or Attend after death Director:

r than "natural", or items 23a or 28a-f the Medical Examiner must be notifie

Hygiene.

permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If Nem 27 is marked other any injury or other traumatic event.

Baltimore, Maryland 21215-0020

thin 24 hours aft the Funeral Di mpietely filled in within 2

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tariq Mahmood M.D. 2300 Dulaney Valley Road 31. Date filed (Month, Day, Year) SEP 2 3 1998

29a. Certifier

(Check only one)

29b. Signature end title of certifier

Medical

32. Registrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

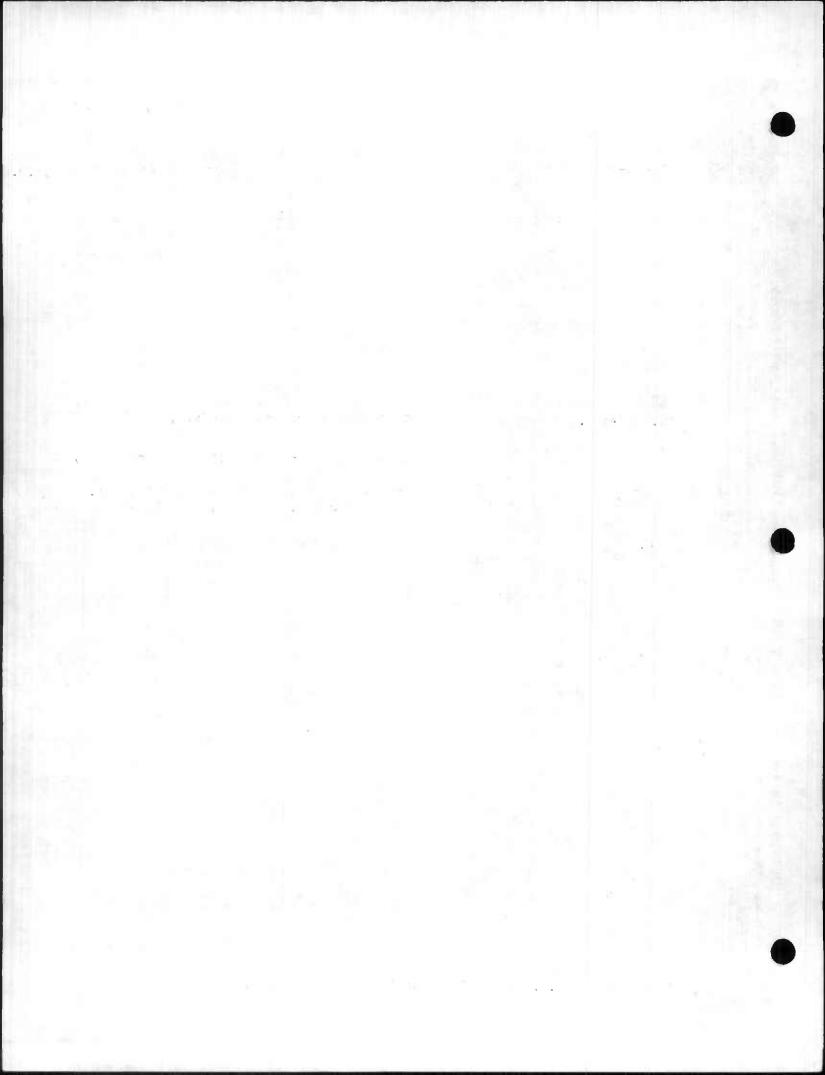
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29d. Date signed (Month, Day, Year)

21093

9/18/98



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month september 20,1998 (-30pm homas 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Baltimere Md. Baltimore. itospital Baltimore, inai ot If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) . Sex 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1 M 2 KF 220-14-5967 90 January 10, 1908 Mary Land Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1♥ Yes 2□No Maryland N/A Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 6133 Marlora Road 21239 United States Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Harvey E Webster Anna Perkins 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) John W. Thomas, Jr./Son 7004 Sherwood Road Baltimore, MD 21239 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burial 2 Cremetion 3 Removal from Stete Moreland Memorial Park 9-22-98 Parkville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Neme end Address of Facility 1. Sitte Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, MD 21212 Approximete Intervel Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in death) cture Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieled events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown

Physician /Medical Examiner

Physician /Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any higher or other traumetic event, the Medical Examiner must be notified at once.

3altimore, Maryland 21215-0020

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Certification:

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29a. Certifier

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Box 68760 Division of Vital Records, death. or Attend after death Director: / To the Hospital or within 24 hours aft To the Funeral Di completely filled in

COPOROSIS rioscleratic Disease 25. Was exa 1

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1 ☐ Yss 2 ☐ No 24e. Wes en autopsy

performed'

(Check only one)

24b. Were autopsy findings eveileble prior to completion of cause of death?

1 Yes 2 No

1 Ves 2 No

Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 X Yes 2 □ No	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
Menner of Deeth 1 □Naturel 5 □ Pending	28a. Dete of Injury 10 28c. Injury 28c. Injury 28c.	Injury et 28d. Describe how injury occurred Work?							

Work? Injury 10 98 1 Yes 2 No 1103 M

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office

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1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. 29b. Signature and wheel certifier laner

Investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year) Tember 21.1988

Baltimore, Md. 21201

30. Name and andress of person who completed cause of deeth (Item 23e) (Type, Print) 31. Dete filed (Month, Dey, Year) SEP 2 3 1998

III Penn Street estaner 32. Registrer's Signeture

State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Franklin H. Williams, Sr. Sept. 18, 1998 8:40 P.M. 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Mariner Healthcare - North Arundel Glen Burnie Anne Arundel # Under 1 Year | # Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | 9. Birthplece (Stere Country) | Sept. 30, 1927 | Maryland 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1**X** M 2□ F 70 10b. County 10c. City. Town or Location 10d. Inside City Limits Anne Arundel Glen Burnie 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of Whet Country? 1026 First Street 21060 United States 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bieck, White, etc. Armed Forces r
1 Yes 2 No
If Yes, Give
Yeer or Detes: 1945 - 146 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorcad 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry State Government Elementery/Secondery (0-12) College (1-4or 5+) Ground Maintenance Airport 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Williams Evelyn 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Lillian Wilkie/ Friend 401 New Jersey Ave., N.E., Glen Burnie, MD 21060 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stete Sept. 21 1 월 Burial 2 ☐ Cremetion 3 ☐ Removei from State Glen Haven Mem. Pk. 1998 4 □ Conetion 5 □ Other (Specify) Glen Burnie, Maryland 21. Signature of Foreign Service Dipensee -22. Name end Address of Fedility
Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth OVI Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 28. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28h Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined

/Medical Examiner Box P.O. Records,

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permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum

Physician

Baltimore, Maryland 21215-0020

5. Sociel Security Number

219-22-7605

10e. Street end Number

20e. Method of Disposition

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Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Lest

1 Yes 2 No

27. Menner of Deeth

1 Naturel

2 Accident

3 Sulcide

29a. Certifier (Check only one)

4 Homlcide

29b. Signeture end title of certifier

11 Marital Status

Usual Residenca of Decedent

Physician/Medical À Completed Be To Certification:

2 9080 certificate this s Alter death after death Director: 24 hours a e Funeral I Hospital To the within 2 To the

Division of Vital

31. Dete filed (Month, Dey, Year) 1998 State Registrar

Medical

29c. License number D39041

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piace, end due to the ceuse(s) end manner steted. 29d. Dete signed (Month, Dey, Year)

Location (Street and Number or Rural Route Number, City or Town, Stete)

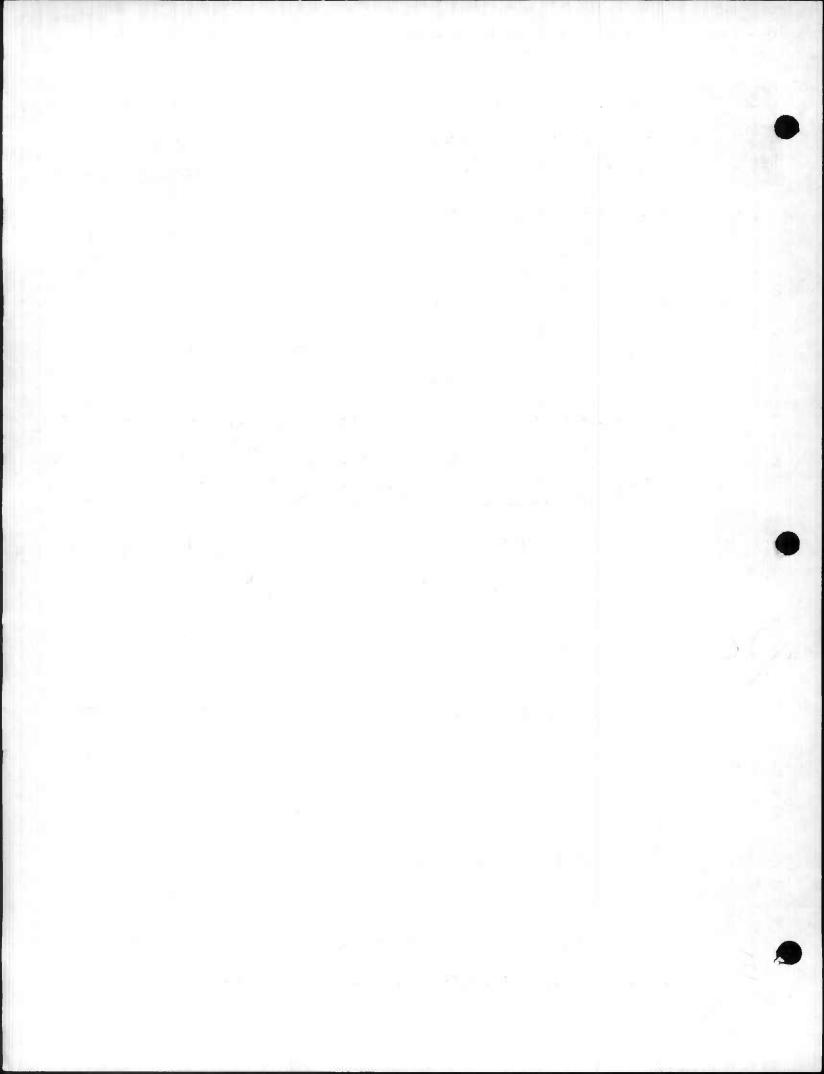
September 21, 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Garatri Nimmagadda, M.D., 3001 Hanover St., Baltimore, MD

Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Régistrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPTEMBER 21, 1998 cation of Death 4c. County of Death 35 KM LOA /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA MARIS MERCY BALTIMORE AT If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 10 M 20 F Months Hours 215-34-8632 109 Yrs. VA Director Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-t show BALTIMORE 1 Ves 2 No MO NIA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? GRANADA 'natural', or Itama 23a 21215 USA UENUE Funeral 11. Meritel Status 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry fled within 7 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) SERVICE BALTO 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be h and Mental I Pages 1 and 2 should be LINWOOD LAWSON JACKSON LRENE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health at Important: If Item 27 is any Injury or other trau DAWMEN 21244 LAUGHTER ONSTANCE MD. 20b. Place of Disposition (Name of cemetery, cremetory or other place 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 Buriel 2 □ Cremetion 3 □ Removal from State KANDALISTOWN 4 ☐ Donation 5 ☐ Other (Specify) YARK 22, Name and Address of Fecility VAUGHN C. GREENE 21. Signeture of Funerel Service Licensee FUNERAL SERVICE reen 5151 BALTO. are PIKE. BALTO. MD. MATL 23a. Part1. Enter the rease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer full ure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical METABOLIC ACIDOSIS 8 hours Examiner Due to (or as a consequence of) Examiner factions Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last end Due to (or as a consequence of) Renal cell Carcinoma Vears Physician/Medical 2 Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 3 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? paged 1□ Yes 2KNo 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? STEZM Certification: To Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 | Yes 2 | No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation n 24 hours after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Division of Vital

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State Registrar

edicai

29e. Certifier

(Check only

29b. Signature and title of certifier

31. Dete filed (Month, Day, Year)

Tomon

SEP 2 3 1998

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Ecrtifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner as stated

2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) and manner steted.

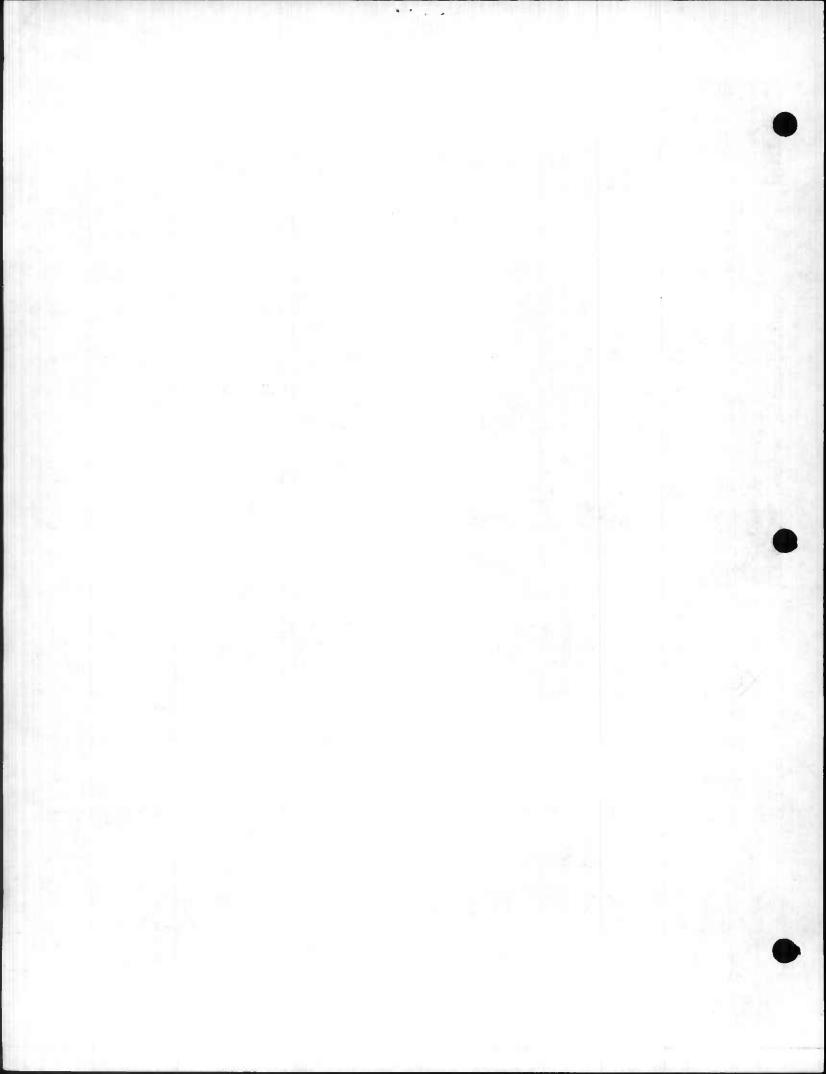
29c. License number

29d. Date signed (Month, Day, Year) September 22, 1998

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO FERRO

relain 120 7672 21236 Be NO

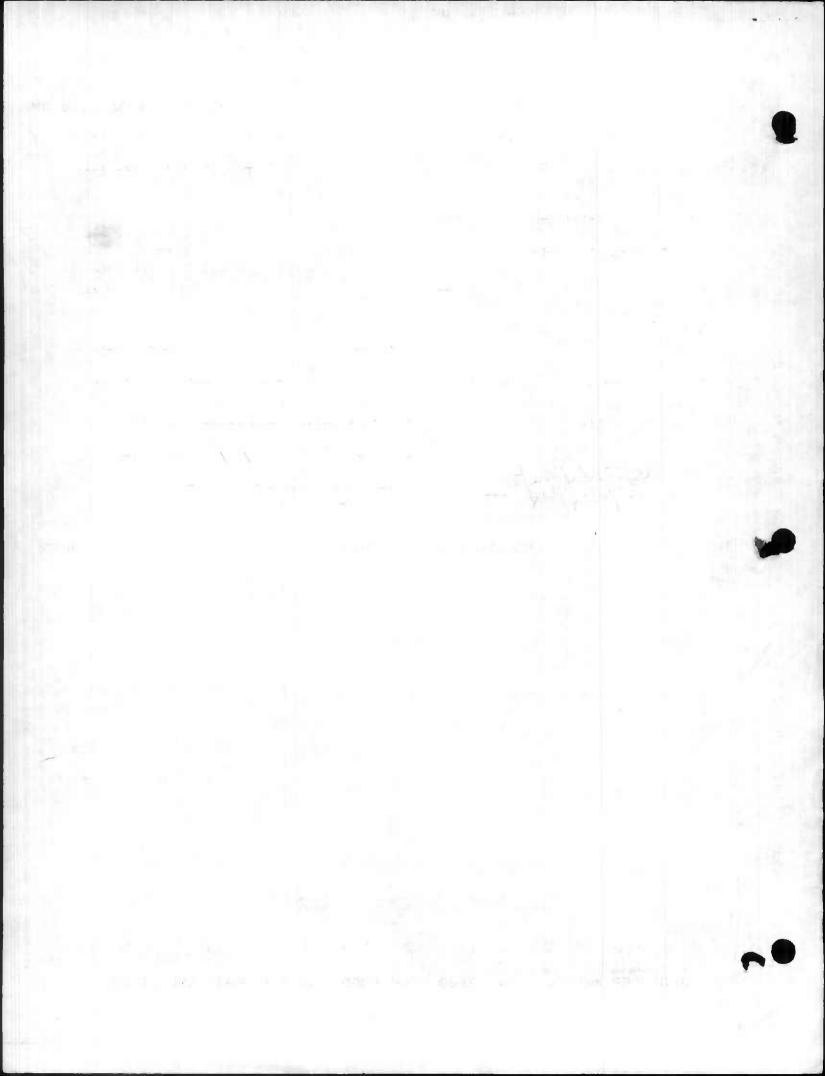
32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** Lyle Wallis SEPTEMBER 21,1998 6:10 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore 7. Age (In yrs. last birthday) | 11 Under 1 Year | 11 Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Eeb. 1, 19 5. Social Security Number 6. Sex 9. Birthplaca (State or Foreign **Eunéral** 1⊠M 2□ F Country) Michigan 374-10-7233 Director Usual Residence of Decedent death with the Maryland 10a. State 10b, County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or hama 23a or 28a-f ahow the Medical Exampler must be nothing at 1 ☐ Yes 2 No Director Md. Baltimore Towson 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 917 Ellendale Drive 21286 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ Ne WWII Year or Datas: "natural", or Itama Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11 Marital Status Black, Whita, atc. filed within 72 hours after Hyglens. ther than "natural", or its 1 Never Married 2 Married aitimore, Maryland 21215-0020 White 1 Yas 2 No Specify: Specify: à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahould be filed will Department of Health and Mental Hyglen Important: if item 27 ie marked other that eny injury or other traumatic event, that page. Engineer Martin Marietta 17. Father's Nama (First, Middle, Last) 18 Mother's Name /First Middle Maiden Sumame) Be George Wallis Ida Marie James 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lyle P. Wallis 2576 Mindi Drive, Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta Data 1 Burial 2 Cremation 3 Removal from Stata New Cathedral 9/24/98 5 Other Baltimore, Md. 4 Donation 21. Signatore Funera 22. Nama and Address of Facility Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. ErnestLL eist, III Approximate Intervel Between Onset and Death **Physician** ASPIRATION PNEUMONIA **VMedical** Immediata Causa (Finel 7 DAYS diseasa or condition rasulting in death) Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PARKINSON'S DISEASE Records, by Completed 24b. Ware autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yas 2 No 1 ☐ Yes 2 No certificate Division of Vital Attending Physician: director. 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2No Certification: To After thi funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Natural 5 Pending death. To the Hospital or Attendif-within 24 hours effer death. To the Funeral Director: Al completaly filled in by the fu invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical (Check only one) 29b. Signature and title(of certified 29c. License number 29d. Data signed (Month, Day, Year) millia m.o D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER MEHTA, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204 31. Data filed (Month, Day, Year) SEP 2 3 1998 32. Registrar's Signature State Dacks/ Registrar

DHMH 16 Rev 6/95



State Registrar 31. Dete filed (Month, Dey, Year) SEP 2 3 1998

29b. Signature and title of certifiar

(Check only one)

EStaner 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signatura

30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29c. Licansa number

O.C.M.E.

29d. Date signad (Month, Day, Year)

SEPTEMBER 20, 1998

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020		by Funeral		rried 2 Marr		12. Was Dece Armed Fo 1 Yas If Yes, Giv Yaar or Do	≱⊡ vNo e	U,S. 1:	3. Was De If Yes, s		_	panic Orig , Mexicen, Spacify:	in? (Spe Puerto I	ecity Yas or No Rican, etc.)		14. Race - American inde Black, White, etc. Specify: Whi				
Is	within ane.	Completed	(Spe Elamantary/Sec 12	15. Decedan ecify only higher condary (0-12)				(Gi	16a. Decedent's Usual Occupation (Give kind of work done during most of working inte. DO NOT use retired) School Teacher					ng	16b. Kind o	Business				
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Baltimore,	00 0 = 7			sposition Cremation County Other (S		emoval from !	State	Place of Dis cemetery, c orthsi	rematory	or othe	r place,		pt.	Date 11,199	20c. Locati 8 Bu	on - City of		ite		
Balt	permit. Page Department of Important: If any Injury or		21. Signature of F	DD	Q	Sles	X:		1501	E.	For	rt Av	enue	Funera Balt	imore		21230			
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× 68760,	tificate ng phys as the	Physician/Medical	Causa (Disaasa o that initiated even resulting in death)	ts	c d		Due to	or as a cons	equance	of):							!			
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ecord	aw requir ts been s 2 should	Completed												24a. Was	s an autopsy ormed?		available complatio of daath?	n of cause		
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Vital	Physician: this centific ral director,	0 8	axaminar?		-	ospital:	npatient 2[☐ ER/Outpat	ient 3	DOA	Other	**		me 5.XXXes		Other (So	ecify)			
	ding h. After fune	-	27. Mannar of Das 1 ☑ Natural 2 ☐ Accident			28a. Date		28b. Time Injur	of	-	Injury : Work i			28d. Describe			-3.,,			
Division	or Attendiation of a star death. Director: A sin by the f	ertification:	3 ☐ Suicida 4 ☐ Homicide	6 Could daterm	not be ined	28e. Place building	of Injury - At ng, etc. (Spec	homa, farm,	streat, fac	ctory, of	ffice			28f. Location (Street and Number or Rural Route Number, City or Town, State)						

To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by bompletely filled in by the funeral director, page 2 should be detected. Completed by Ph Be Medical Certification: To

29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Valedical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licanse number 29d. Date signad (Month, Day, Year) 29b. Signature and title O.C.M.E SEPT. 8, 1998

completed cause of death (Item 23a) (Type, Print) ph

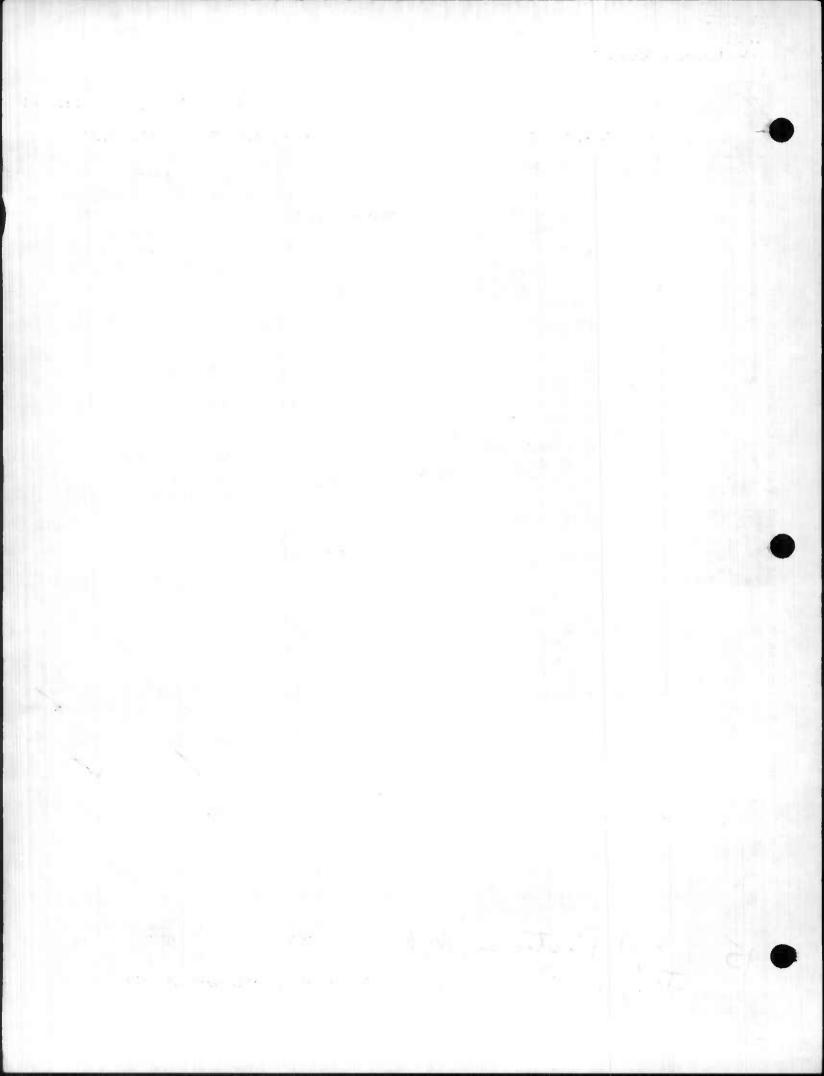
Tanco 111 Penn Street, Baltimore, Maryland 21201

State Registrar

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31. Date filed (Month, Day, Year) 32. Registrar's Signatura

SEP 2 4 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 18:10 pm ADAMS LILLY SEPTEMBER 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MARYLAND MEDICAL DYSTEM BALTIMORE UNIVERSITY DF If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Yaar) if Under 1 Year 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthpleca (Stete or Foreign Country) Months Days 213-22-6041W 1 □ M 2 M F 55 North Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ¥Yas 2 □ No N/A Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3229 Road U.S.A Carver 21225 12. Was Decedent Ever In U,S. Armad Forcas? 1 ☐ Yes 2 Ø No If Yes, Give Year or Datas: 14. Race - American Indian, Black, White, etc. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 11. Marital Status 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Nidowed 4 Divorced 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 100 Nursing Cross 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Jones Jesse Mary Conyers 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 901 Seagul) 20b. Place of Disposition (Name of cemeter), cremetery or other place) Avenue, Baltimore, MD 21225 Dete 200. Location - City or Town, State Billie Mitchell 20e. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removel from State 9/26/98 Baltimore, Maryland 4 Donetion 5 Other (Specify) Cem. Zion 21. Signature of Funeral Service Lice 22. Name end Address of Facility Hari P. Close Funeral Service Mc Culloh St. Baltimore, MD 21217 701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Ceuse (Finel disaesa or condition resulting In deeth) EMORRIHAGE Due to (or es e consequence of) COAGULOPATHY

Physician /Medical Examiner

physician and s the bunel-transit

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

by

Completed

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Certification: To

Medical

Physician

/Medical

Examiner

10e. State

Director

Completed by Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mantel Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show eny Injury or other traumatic event, the Madical Exercises must be not ned.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)

Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

22 SOUTH

32. Registrer's Signeture

ANDERSON, MD

31. Dete filed (Month, Dey, Yeer) SEP 2 4 1998

thet initiated events resulting in deeth) Last	Due to (or as a consequence of	f):		7	
Part II. Other significant condition	s contributing to death but not re	sulting in the underlying	g cause given In Part I.	23b. Did tobecco use co 1 ☐ Yes 2 X No	ntribute to the cause of death? 3 Probably 4 Unknown	
				24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of cause of death?	
25. Was case referred to medicel			28. Place of De	eeth (Check only one)		
axaminar? 1 Yes 2 No	Hospitel: 1 Inpatiant 2	☐ ER/Outpatient 3☐	me 5 Residence 6 Other (Specify)			
27. Menner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day Year)	28b. Time of injury	28c. Injury et Work?	28d. Describe how injury occur	red	
3 Suicide 6 Could no 4 Homicide detarmin		home, ferm, street, fact	28f. Location (Street and Numb City or Town, State)	per or Rurel Route Number,		
29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physicien: To the best of my kn compar: On the basis of exeminand manner steted.	owledge, death occurre etion and/or Investigation	od et the time, dete end plac on, in my opinion, death occ	ee, end due to the ceuse(s) end me curred at the time, date and place,	anner as steted. and due to the cause(s)	
29b. Signature and title of certifier		2	9c. License number	29d. Date signe	d (Month, Dey, Yeer)	

SEPTEMBER 20, 1998

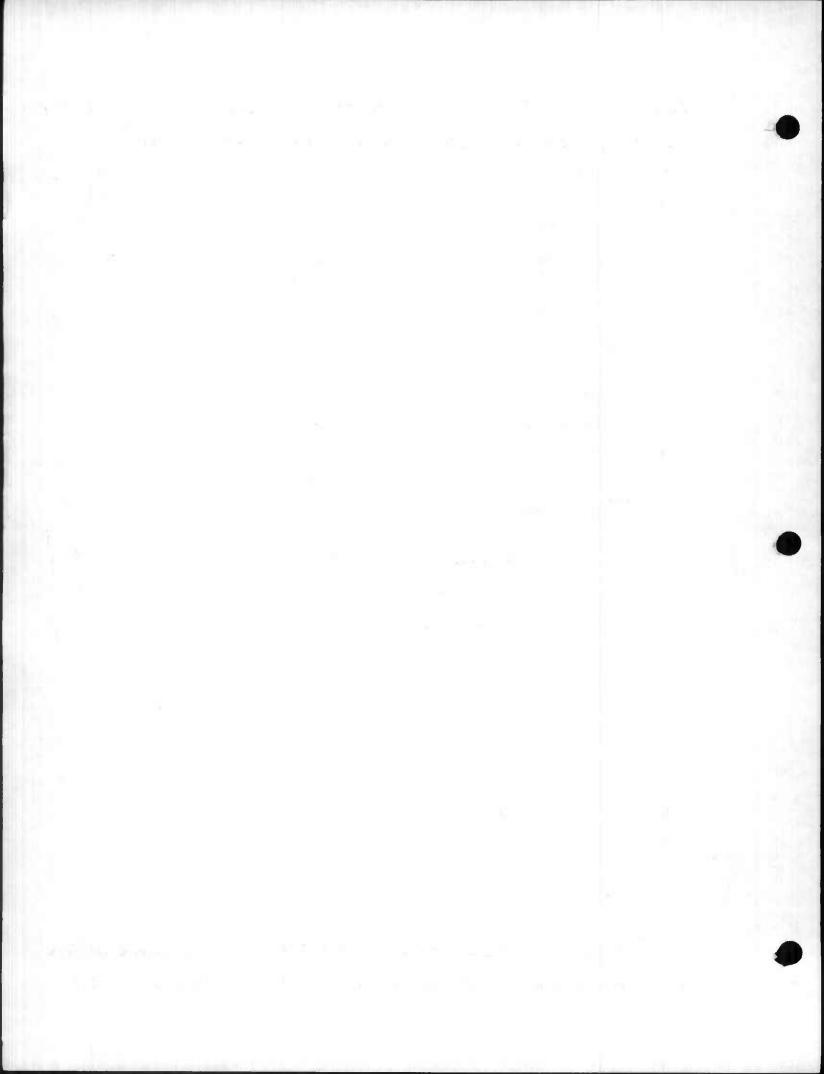
GREENE STREET BALTIMORE, MARYLAND 21201

State Registrar

within 24 hours after dear To the Funeral Director: filled in by

completely

Hospital



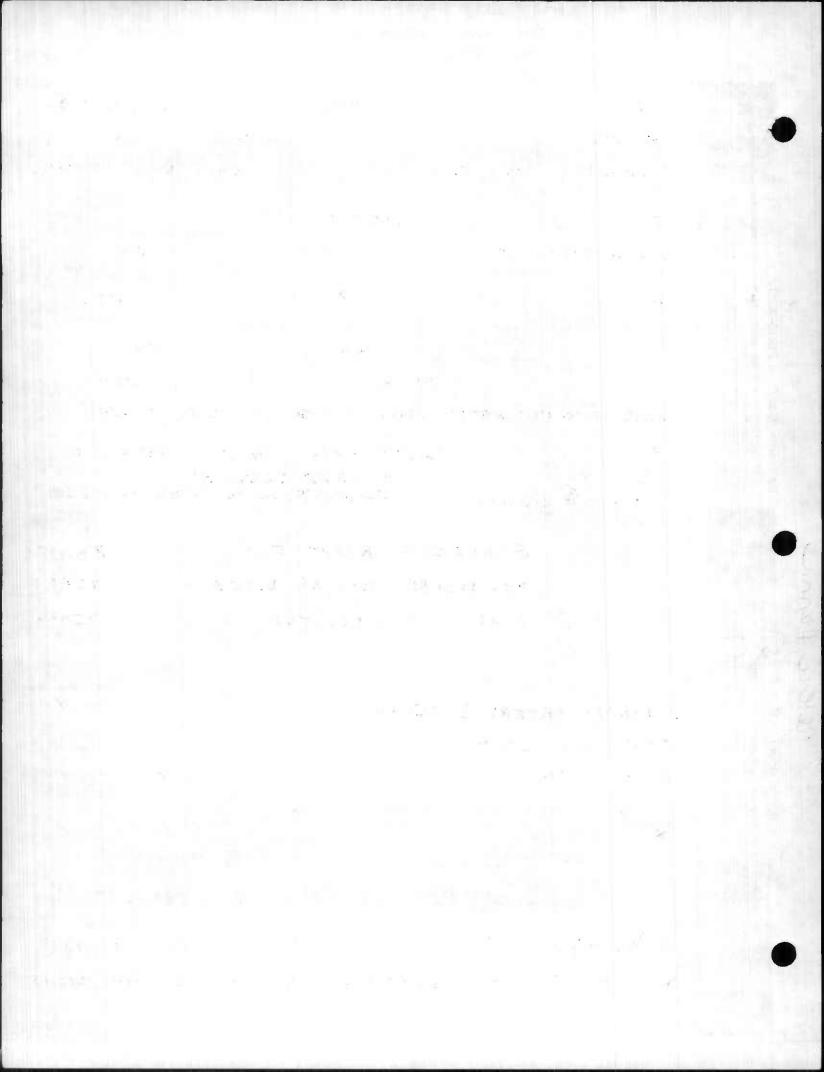
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death 3. Tima of Death Month **Physician** 1998 ALTERAC SEPT 18 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE LEVINDALE 5 Social Security Number 8. Dete of Birth (Month, Day, Year) AUG 1, 1905 9. Birthplaca (State or Foraign 7. Age (In vrs. last birthday) **Funeral** Months Deys Hours 10 M 20 F YUGOSLAVIA 218-26-9229 93 Yrs. Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10e State 10b County 10c. City. Town or Location r 28a-f show 1 ¥Yas 2 No Director BALTIMORE N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "naturel", or items 23s or traumatic event, the Medical Examiner must be 1 21215 LISA 2435 W. BELVEDERE AVE. Funeral filed within 72 hours after death 14. Reca - American Indien, 12. Was Decedant Evar in U,S. Armed Forces?

1 Yes 2 No
Il Yas, Give X Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11 Maritel Status Black, White, atc. 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 X Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Industry 15. Decadent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 18. Mother's Neme (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) . Pages 1 and 2 should be filk ment of Health and Mental Hant: if item 27 is marked oth jury or other traumatic even UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print)
RENEE RITTNER (SOC. WORKER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO., MD 21215 2435 W. BELVEDERE AVE. 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removel from State permit. Page Department of important: If any injury or 9/23/98 BALTIMORE HEBREW BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 2501 LEVINSON & BROS., INC. PIKESVILLE, MD 21208 8900 REISTERSTOWN RD. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heer failure. List only one cause on each tine. Approximate tnterval Between Onset and Deeth Physician Immediate Cause (Final disaese or condition resulting in death) /Medical GANGRENE RIGHT 3 MONTHS **Examiner** Due to (or es a consequenca of): PERIPHERAL VASCULAR DISEASE YEARS Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Lest YEARS DIABETES MELLITUS Division of Vital Records, P.O. Box 68780 Physician/Medicai Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE þ 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes an autopsy performed? Completed SCHIZOPHRENIA DEMENTIA 20 No 1 Yes 2 No 25. Was case referred to medicat examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 1 Natural 5 Pending Investigation after death. Director: Alt 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(a) and manner stated. 29a. Certifier edicai (Check only one) Within 2 To the 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signature end title of certifian D51107 lle M.D. 30. Nema end address of person who completed cause of deeth (Item 23a) (Type, Print) BALTIMORE, MD 21215 LEVINDALE. M.D.

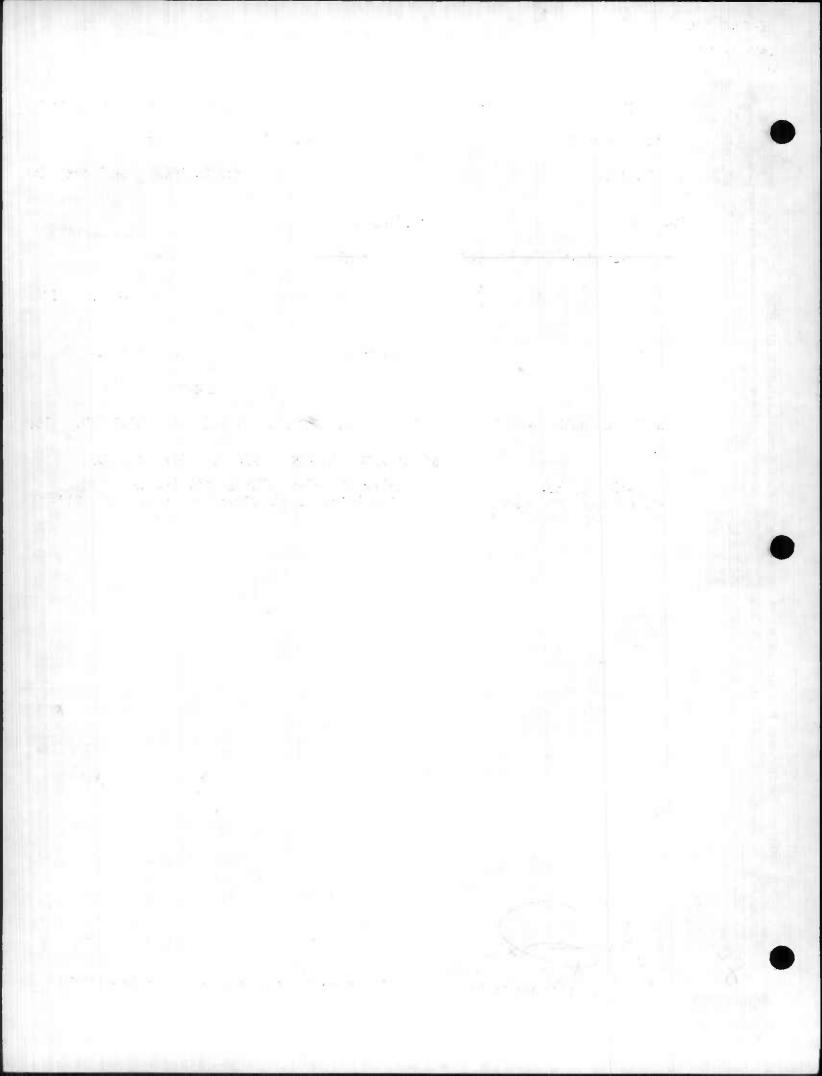
32. Registrer's Signature

State Registrar

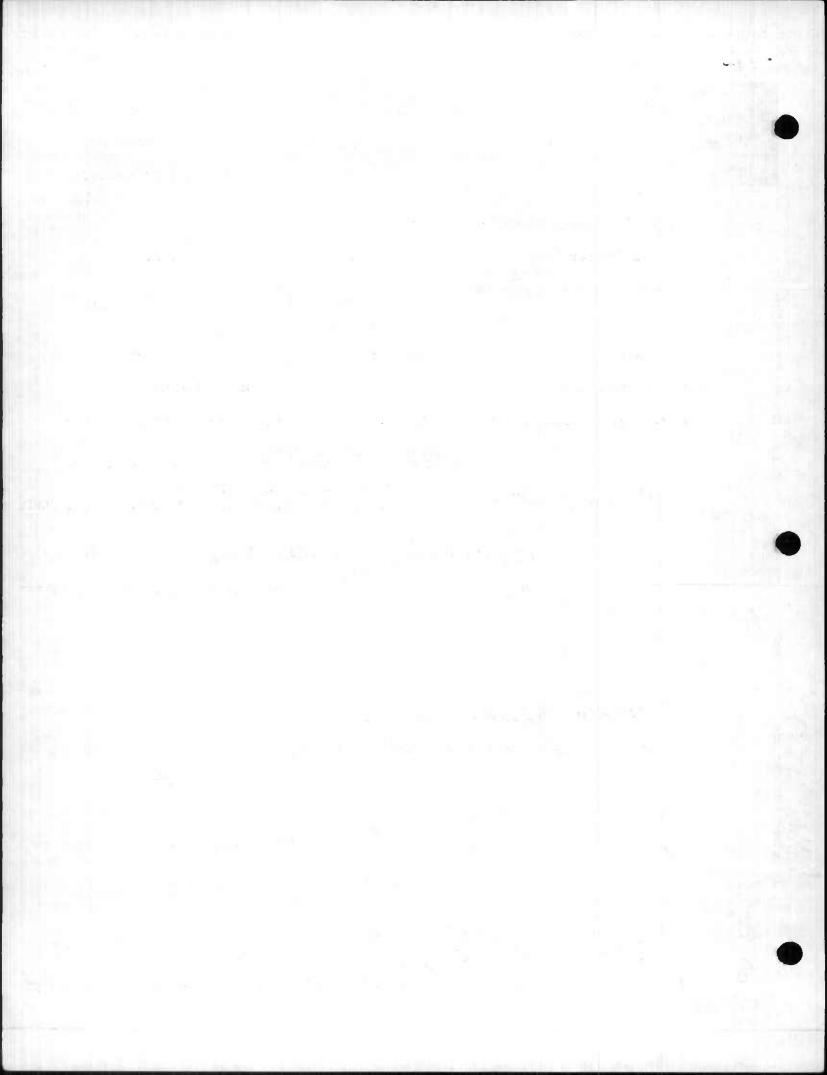


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	the etter	sici	Part II. Other significant conditions co	ontributing to death t	out not resu	Iting in the ur	nderlying c	ause gi	ven in Part I.		23b. Dld	tobacco use co	ntributs to	the cause	of death?	
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	/		1 Ass	San				O.C	.M.E			AUGUST	23,1	998		
	8		30. Name and address of parton who	completed cause of	death (Item			2022	Ctro	h 1	Ral + imo	ore Mary	land	21201		
	Sta	te	31. Date filed (Month, Day, Year)	MA	rar's Signet	- 4	do		-	st, l	рат г.шк	ле пату.	LOIM	C1201	•	
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/Medi Exami		4e. Fecility Nama (If not institution,	give street end num	nber)	-111		4b. City, Town,	or Location of Dea	ath 4c. County	of Death	0.700
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death with the Maryland ms 23s or 28s-f show	tor	Maryland Princ	e George'	s Bo	wie						tXXYas 2□
or 284	Directo	10e. Street and Number				10f. Zip Coda			10g. Citizan of	What Cou	ntry?
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filed within 72 hours affer dea Hygiene. ther than "natural", or items ent, the Medical Exercitor or	Funeral	11. Maritai Status	Armed For		5. 13. Wa	s Decedant of as, specify Cul	Hispenic Origin? ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo- 14. Rad Bia	ce - Amari	can Indian, atc.
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ortant: Injury		21. Signature of Funeral Sarvice Li		Ceme	tery 22. N	iama and Addr	9/07/193	98	Washing	gton,	D.C.
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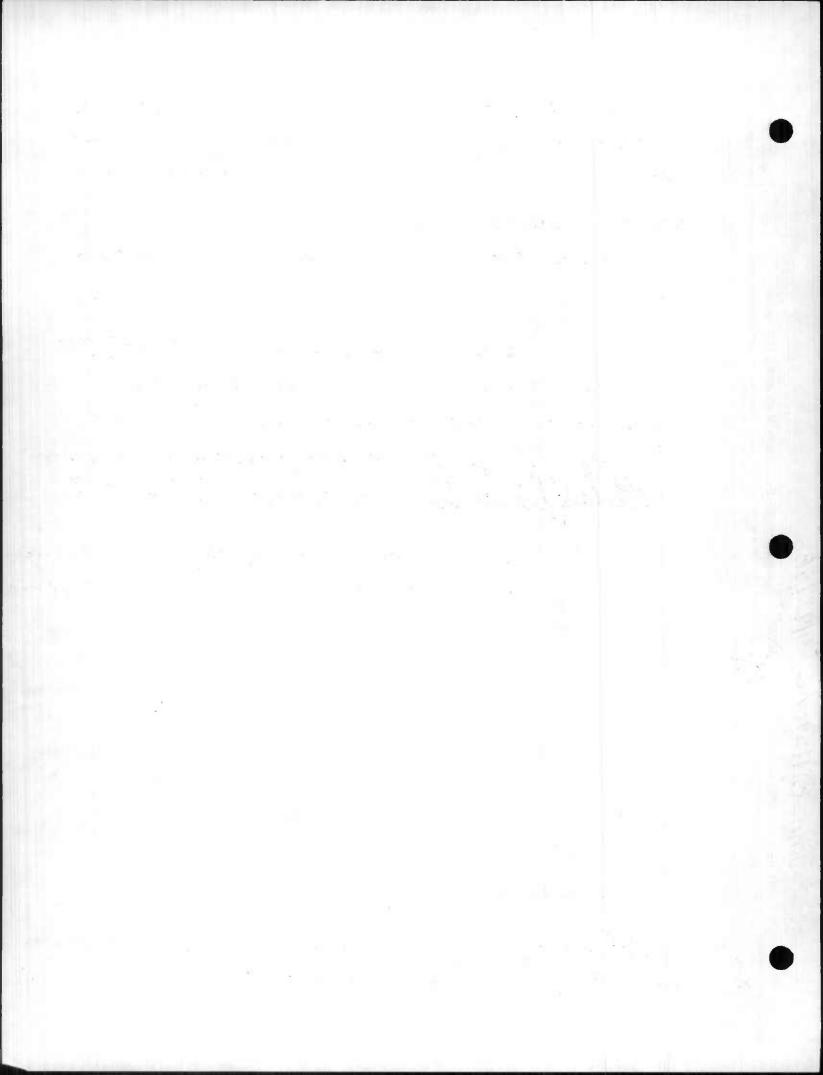
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death Month **Physician** John A. Billstone September 22, 1998 4:05 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Co. Towson Pickersgill If Under 1 Year If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2 F Months Days Hours Yrs. 80 Ohio 520-07-3959 01/27/1918 **Director** Usual Residence of Decedent the Maryland 10a. Stete 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Directo Baltimore Co. Towson Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Modical Examiner must be an once. 21204 United States 506 Piccadilly Road Funeral 14. Reca - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Ø Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) National Bohemian 4 yrs. Corporate Executive Brewery 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Rebeka Eckstrom Frank Albert Billstone Sarah 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 35 Windemere Parkway Phoenix, MD Debbie B. Sperato / Daughter 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Dulaney Valley Mem. Gardens 9/24/98 Timonium, Maryland 4 Donetion 5 Other (Specify) 22. Name end Address of Fecility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, of a inplications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List, r ly one cause on each line. Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical newopathy Severe sensory **Examiner** Una CANCEY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to Completed 24e. Was en eutopsy performed? completion of cause of death? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 89 Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28e. Date of injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 Naturai 1 Yes 2 No 2 Accident after deat Director: 6 Could not be determined 28e. Pleca of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 | Homicide 24 hours Funaral Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

— Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) Within 2 To the F 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier 125205 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto, MIS GBINC 6701 Le 2. Registrar's Signature State Registrar

Billstone

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend: #23b,24a,25,26,29c,30 Per MD Film G763 9-24-9880 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 9 6:18 pm Bookman /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Mary Ima Ba Homore Miversity 7. Age (In yrs. last birthday) al Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 217-40-7382 1₩ M 2□ F 56 Yrs. Director unknown Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 832 1/2 W. Lombard Street Apt 101 21201 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces? unknown

1 ☐ Yes 2 ☐ No
If Yes, Sieve
Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ KNo Specify: 14. Race - American Indien, 11. Marital Status Black, White, etc. Never Merried 2 ☐ Married Baitimore, Maryland 21215-0020 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " College (1-4or 5+) Elementery/Secondary (0-12) unknown unknown unknown unknown 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Joseph Bookman June Saxon 20 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Livingston/sister 20b. Piace of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cametery, crematory or other placa) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from State b 5 Other (Specify) in state Euneral Service Licensee Ronald S, Wade, 22 Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Director Kul Baltimore, Maryland 21201 th. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immune Deficiency Syndrome /Medical immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequenca of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last buriel-tren Due to (or as a consequenca of): Physician/Medical the Due to (or as e consequenca of): signed by the eld be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2♥ No 3 Probably 4 Unknown by Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed has page 2 1 Yes 20 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠ No Certification: To 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Neturei 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner es stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29e, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) P12513 30. Name and address of person who complete cleause of death (item 23e) (Type, Print) WENDY WRIGHT, MD 22 S. GREENE STREET, BALTIMORE, MD.

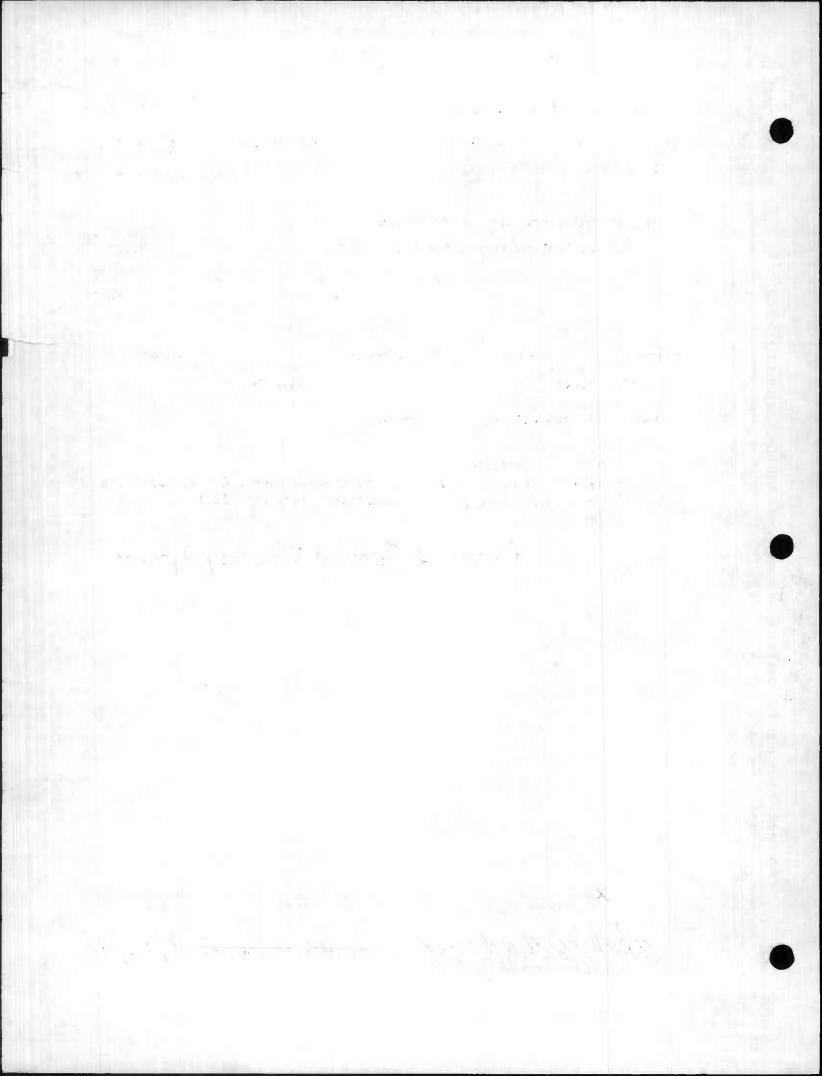
Registrar

State

31. Date filed (Month, Day, Year) SEP 2 4 1998

32. Registrar's Signature

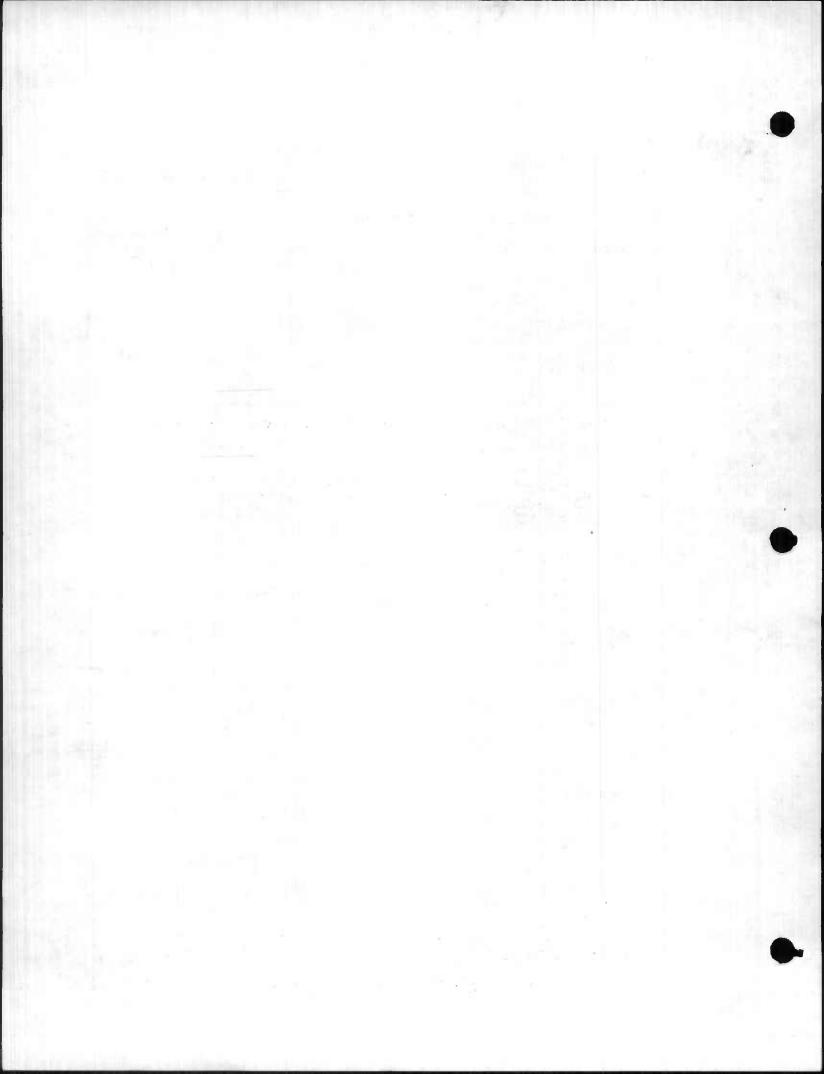
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) Physician 1. Decedent's Neme (First, Middle, Last) Physician 2. Dete of Death Month Day Year 3. Time of Death Month Day Year

#18,20b Pe	r FH Film G763 9-24-98R0		Certifica	te of Death	Re	g. No.	69225				
Dharatalan	1. Decedent's Neme (First, Middle, Last)			2. Dete of Death Month	Day Year	3. Time of Death				
Physician /Medical	STUVIA	BROWN			SLLT	13 198	P 2:17h,				
Examiner	4e Facility Neme (If not institution, give	street end number)		4b. City, Town, o	r Location of Death	4c. County of Del	ath				
	NORTHWEST HOSPITA	T. CENTER		DANDAL	LSTOWN	BALTI	MODE				
Funeral	5. Sociel Security Number 6. Sec			r 1 Year If Under 24 H	s. 8. Dete of Birth		rthplaca (Stete or Foreign country)				
Director	Usuel Residence of Decedent	M 2⊠F 74	Yrs. Months	Days Hours Mi	MAY 31		W YORK				
72 hours after death with the Maryland natural, or thems 23s or 28s-f show deal Examiner must be notified at deal by Funeral Director	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits				
to the to	MD BA	LTIMORE	BALTIMORE	2			1 ☐ Yes 2 X No				
or 28e-1 s be notified Director	10e. Street end Number			p Code	10	g. Citizen of What C	Country?				
	2963 MARNAT RD.,A			21209		USA					
Lizamine must	11. Merital Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give A Year or Detes:		dent of Hispanic Origin? ecify Cuban, Mexican, Pu 2 XNo Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:					
eted dire	15. Decedent's Edu (Specify only highest gred		16a. Decedent's Usu (Give kind of we	ork done during most of w	orking 1	6b. Kind of Busines:	s/Industry				
Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	life. DO NOT	use retired)							
S	12		RETA			SALES					
Be	17. Father's Neme (First, Middle, Last)			18. Mother's N	eme (First, Middle, M	aiden Sumeme)	5				
0	NATHAN		STRAUSS	T.	TILLIAN BE	LLA CUTLER					
	19e. Informent's Neme/Reletionship (Ty	pe, Print)	19b. Meiling Addres	s (Street end Number or	Rural Route Number,	City or Town, Stete,	Zip Code)				
	MRS. DEBBY WEINBE	RG (DAUG.)	2409 FOR	REST GREEN R	D. BALTI	MORE, MD	21209				
	20a. Method of Disposition		Plece of Disposition (Ne semetery, cremetory or	me of		Oc. Location - City o					
	1 Burial 2 □ Cremation 3 □ R 4 □ Donetion 5 □ Other (Specify)	lemovel from Stete	HAR SINAI	ourer precey		OWINGS MI	LLS, MD				
	21. Signeture of Funerel Service License	90		EVINSON & B			WD 01000				
	23a. Pert1. Enter the disease, or compl shock, or heert feilure. List only or	Viener-		REISTERSTOW		ESVILLE,	MD ZIZO8				
Examiner The house trainer The house trainer Clical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (c	or es a consequence of)	with h	ite ste	s75					
Physician/M	d										
sic	Pert II. Other significant conditions con	tributing to death but not res	ulting In the underlying	cause given in Pert I.	23b. Did tot	sacco use contribu	te to the cause of death?				
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Completed by		eutopsy ed?	. Were autopsy findings evailable prior to completion of cause of death?								
TO.					1 ☐ Yes	s 2 No	1 ☐ Yes 2 ☐ No				
Be C	25. Wes case referred to medical			26. Placa of D	eeth (Check only one)					
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tion: T	27. Menner of Deeth 1 Natural 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe hor		Conyy				
Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At he building, etc. (Specif.	ome, ferm, street, fector	ry, office	28f. Location (Str. City or Town,	eet and Number or I Stete)	Rural Route Number,				
plately file edical C	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my kno ner: On the basis of examine end manner steted.	wledge, death occurred tion end/or investigation	at the time, date end plan, in my opinion, deeth oc	ce, and due to the car curred et the time, da	use(s) end menner of the and place, and de	es stated. ue to the cause(s)				
To the comple	29b. Signeture end title of certifier		29	c. License number	29	d. Date signed (Moi	nth, Day, Year)				
	> A/IC /	15/		H 4397	14 54	pt 19	1988				
0	Alike Hsix	mpleted cause of death (Item	23a) (Type, Print)	- Hosport	of kan	dillet	unn, hic				
State Registrar	31. Deté filed (Month, Dey, Year) SEP 2 4 1998	32. Registrer's Signe	9. Soon	2							

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1 Decedant's Nama (First Middle Last) 2. Data of Death Day **Physician** 8:32 pm ALBERTA D. BRIGGS September 20 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Sinai Hospital of Baltimore Baltimore If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 12 22 1 Birthpleca (Stata or Foreign Country)
 MARYLAND 10 M 2 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min Yrs. 85 216-20-5770 **Director** Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d, Insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other treumatic event, the Nedical Examiner must be notified at Yas 2□No Directo N/A MD BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? US 3704 DENNLYN ROAD 21215 Funeral 12. Was Decedant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Yas ZONo If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 CXNo Specify: Specify: by 3 Widowad 4 □ Divorced BLK. Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) READING SPECIALIST EBUCATION 12 18. Mothar's Nama (First, Middla, Maldan Surnema) 17. Fathar's Name (First, Middla, Last) Be GREEN TSATAH A. DORSEY SARAH L. 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2944 EDMONDSON AVE. BALTIMORE, MD. 21223 on (Nama of Data 20c. Location - City or Town, Stata LAVINIA DORSEY (SISTER IN LAW) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Department of Important: If It any Injury or o ★₩ Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) BALTIMORE NATIONAL CEMT. 9/28/98 BALTIMORE, MARYLAND 22. Nama and Addrass of Facility E.L. PHILLIPS FUNERAL HOME PA. 21. Signature of Funaral Sarvice Licensaa 1721-27 N. MONROE ST. BALTIO., MD. 21217 CFSP with Dech Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onsat and Death Physician Immediate Causa (Final disaasa or condition resulting in deeth) /Medical Obstructive Jaundice Examiner Due to (or es e consequança of): Physician/Medical Examir Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Ceuse (Disease or injury that initiated avants rasulting in daeth) Last Dua to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of ceusa of death? page 2: 2 NO 1 Yas 2 No 25. Was cese rafarred to medicel examiner? 88 26. Placa of Deeth (Check only ona) Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 1 Yas 2 No 1 Unpatient 2 ER/Outpatlent 3 DOA 10 28d. Describe how injury occurred 27. Manner of Deeth 28a. Data of Injury (Month, Day Yaer) 28b. Tima of 28c. Injury at Work? Certification: 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 ☐ Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, daeth occurred at tha tima, data and place, and due to the causa(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stetad. 29a. Certitier edical (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifian 29c. Licansa number 11931/MH9191 20,1998 September 30. Nama and addrass of parson who complated ceusa of daath (Itam 23a) (Type, Print) Sinai HUSDITchael 31. Data filad (Month, Day, Year) SEP 2 4 1998 32. Ragistrar's Signature State

Registrar

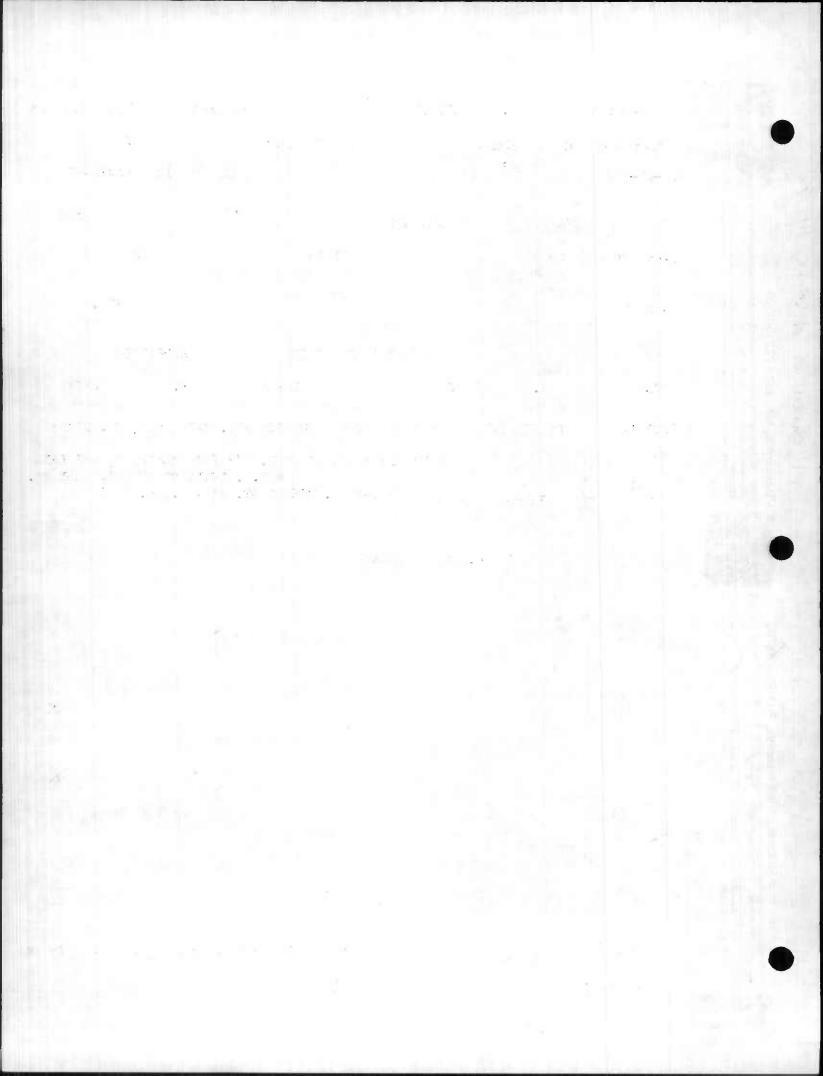
Division of Vital Records, P.O.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Old Federal 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 M 2 F -36-3400 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examples must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 20 No Specify Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ifiled within 7 i Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) URS permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other teny injury or other traumatic aware. 17. Father's Name (First, Middle, Last) Maiden Sumame) 18. Mother's Neme (First, Middle, Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Reletionship (Type, Print) Jappettsville Md 21084 11d 20b. Place of Disposition (Name of cemetery, cremetory or other place) Self 24 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility runce vans Newport FOR Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) Physician/M P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No ă 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Tateral pelmonary Emboldery Completed 24a. Was an autopsy 28 No 1 ☐ Yes 2 ☐ No confilcate 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2⊠ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 쿭 Certification: 27. Magner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Alter Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

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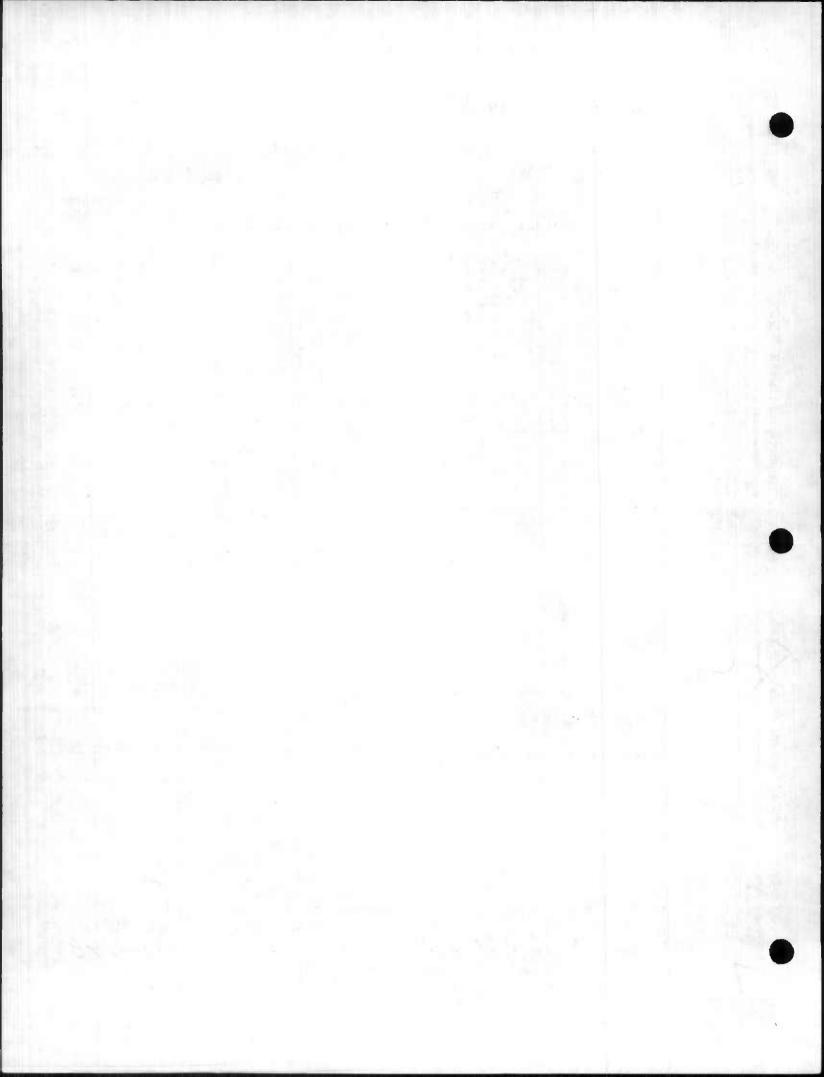
30. Name and address of person

31. Date filed (Month, Dey, Year)

mthee Rd. Suite 102 Bellik

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature



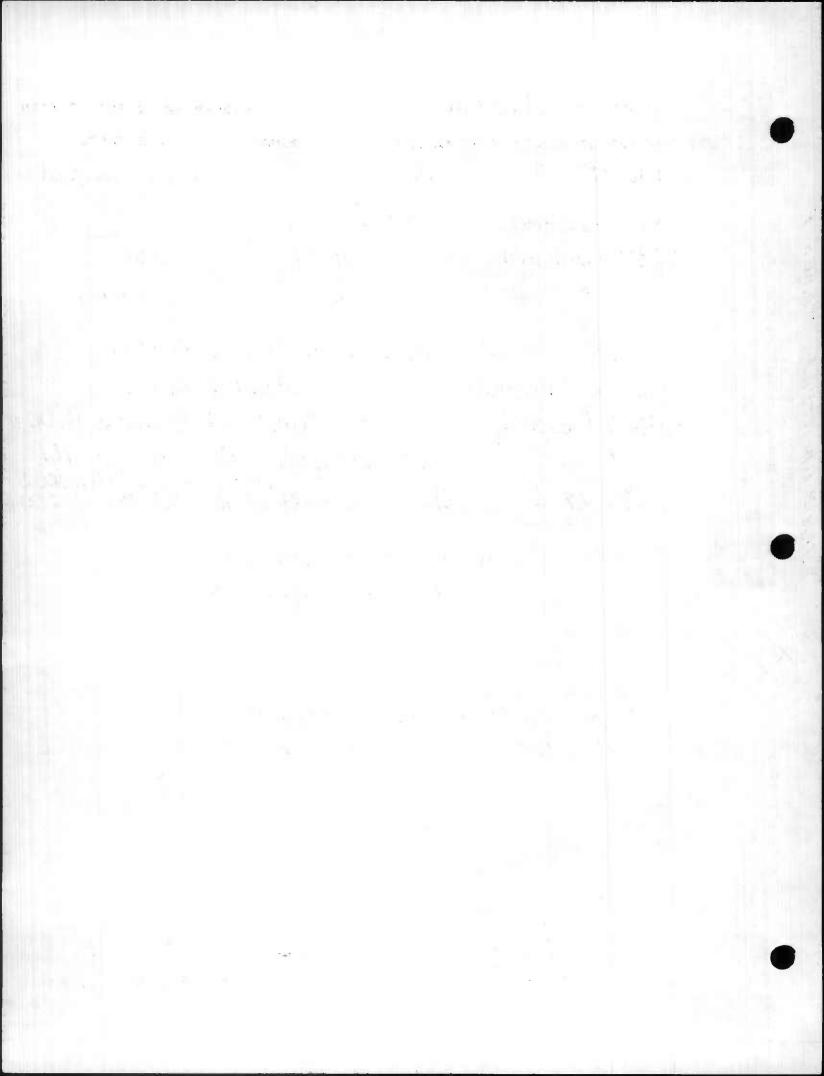
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month **Physician** nristnil 21,1998 SEPTEMBER 7:40PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner BALTIMORE BALTIMORE MEDICAL CENTER TOWSON 5. Social Sacurity Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) If Undar 24 Hrs. 9. Birthplaca (Stata or Fpraign 6 Sax **Funeral** Min Months Days -18-9739 MM 2DF Hours Maryland Director Usual Rasidence of Dacedant with the Maryland 10a Stata 10h Count 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No Director Md 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 7 is marked other than "naturel", or items 23a or traumatic event, the Madical Example, must be a 21234 Funeral 72 hours after death 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Was Decedant Evar in U,S. Armed Forcas? 1 DLYas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - Amaricen Indian 11. Marital Status Black, Whita, at 1 Navar Married 2 Married Specify: White 1□ Yas 2V No Specify: þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Spacify only highast grada complated) Elamantary/Secondary (0-12) Coilega (1-4or 5+) Hygiena. Engineer 124RS 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama YFirst, Middla, Last) Be Maud and Mental 2 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is any Injury or other trau Baltimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Date 20a. Mathod of Disposition 24 1 Buriai 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) 21. Signature of Furieral Service License 04 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying course given in Part I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown à 24b. Wara autopsy findings availabla prior to completion of ceuse of daath? 24a. Was an autopsy performed? Completed frector, page 2 a 2 No 1 □ Vas 2 □ No 1 Yas 25. Was cesa rafarrad to medicel axaminar? 89 26. Placa of Death (Chack only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 Yas \$ No 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of After Naturai Accidant or Attending 5 Panding invastigation 1 Yas 6 Could not be datarmined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida Hospital 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifiar Medical (Check only one) and mannar stated. Within 2 To the F 29d. Data signed (Month, Day, Year) 29b. Signatura and titia of certifiar 29c. Licansa number 30. Nama and addrass of person who donipiate Lasa of death (Itam 23a) (Type, Print)

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State Registrar

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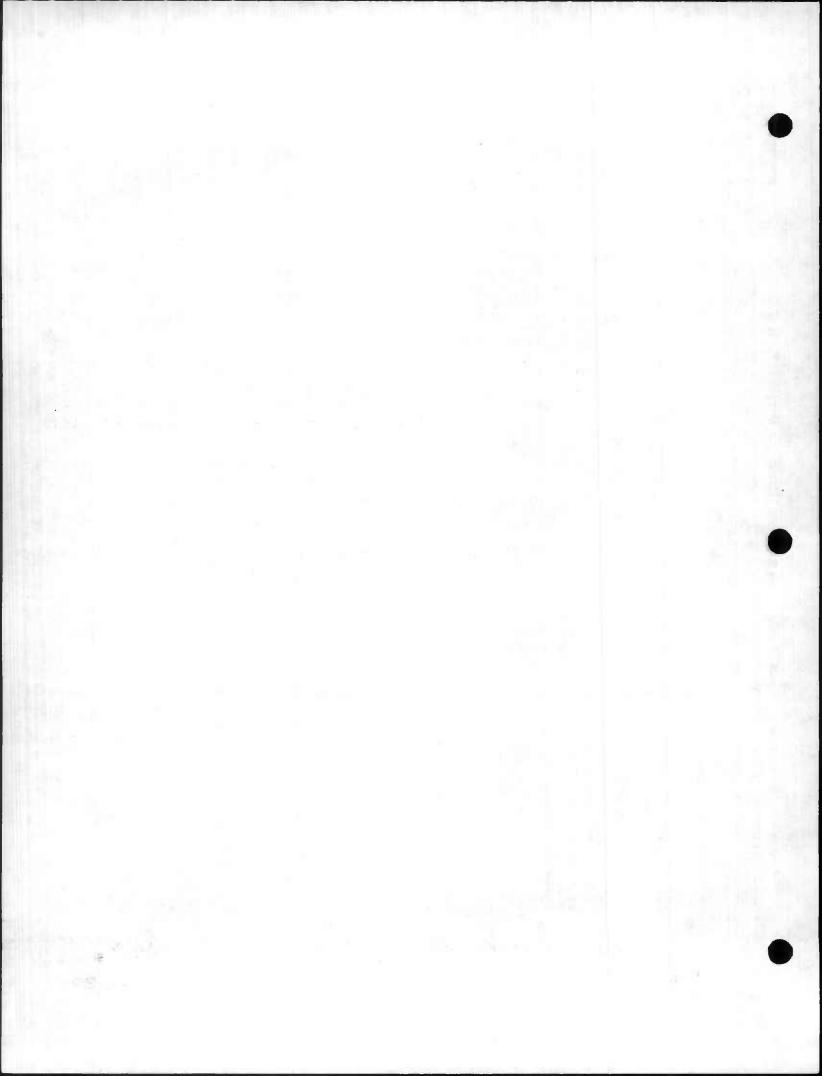
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State of Maryland / Department of Health and Mental Hygiene

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24a. Wes an autopsy performed?	b. Ware autopsy findings available prior to completion of cause of death?	
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30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) DERMOT MORE D'FERRALL, MD 680N.WOZFE ST. BALTIMORE MI	SEPTEMBER 2 1998	
State Registrar SEP 2 4 1998 31. Data filed (Month, Day, Year) SEP 2 4 1998 32. Registrar's Signatura G. Apould		

DHMH 16 Rev 6/95

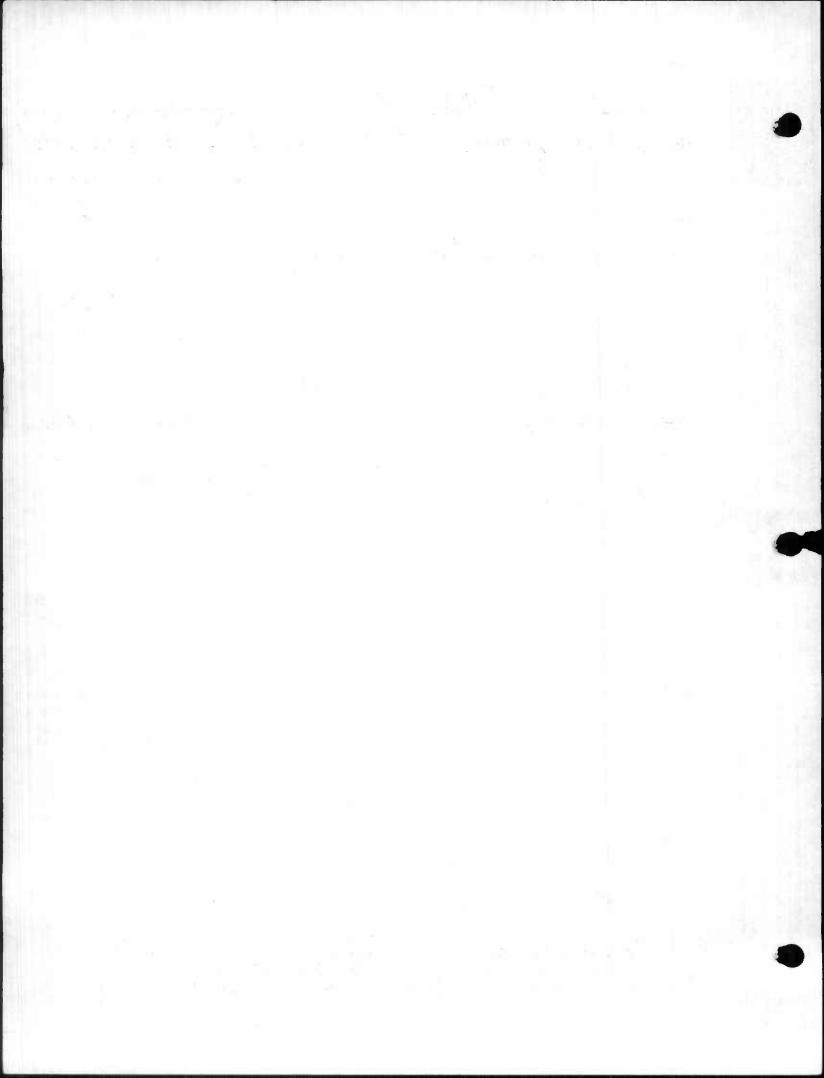


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #2 Per MD Film G763 9-24-98RC Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 9-4-98 3. Time of Death **Physician** /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Ta **Examiner** Mayland House of 5. Social Security Number 6. Set If Under 24 Hrs If Under 1 Yeer 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months Deys Hours 10 M 20 F 214-80-280 Usuel Residence of Decedent -2809 Yrs Director the Marylend 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hyciena. Important: If Item 27 is merked other than "natural", or Items 23s or 28a-f show any Injury or other traumatic event, the Medical Examiner must be invitted apones. BALTIMOLE Yes 2□No Director Yary mo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? EIGHTS USA 21215 Funerai 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Meritel Status Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced ack Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 9th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be PAUI Mary DIES 2 19e. Informent's Neme/Reletionship (Type, Pring 19b. Melling Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) DEBRA Smith 6632 EDELLE # 304 SISTER 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) 21. Signeture of Funeral Service Vicensee 22. Name and Address of Facility CHATM AN 23a. Party: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete tnterval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel disease or condition resulting in deeth) Examiner Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest physician s the buriel Box 68760. Physician/Medical Due to (or as e consequence of): ate has been signed by the ette page 2 should be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco uss contributs to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evalleble prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 1 Yes 2 No 2 No certificate 25. Wes cese referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient Certification: To 2□ No 2 ☐ ER/Outpatient 3 DOA After this 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion within 24 hours efter death To the Funeral Director: A 2 Accident the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner as steted (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner steted. \$ 29b. Signeture end title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 0 death (Item 23e) (Type, Print) DUT Correc 410 U

32. Registrer's Signeture

2 4 1998

State Registrar

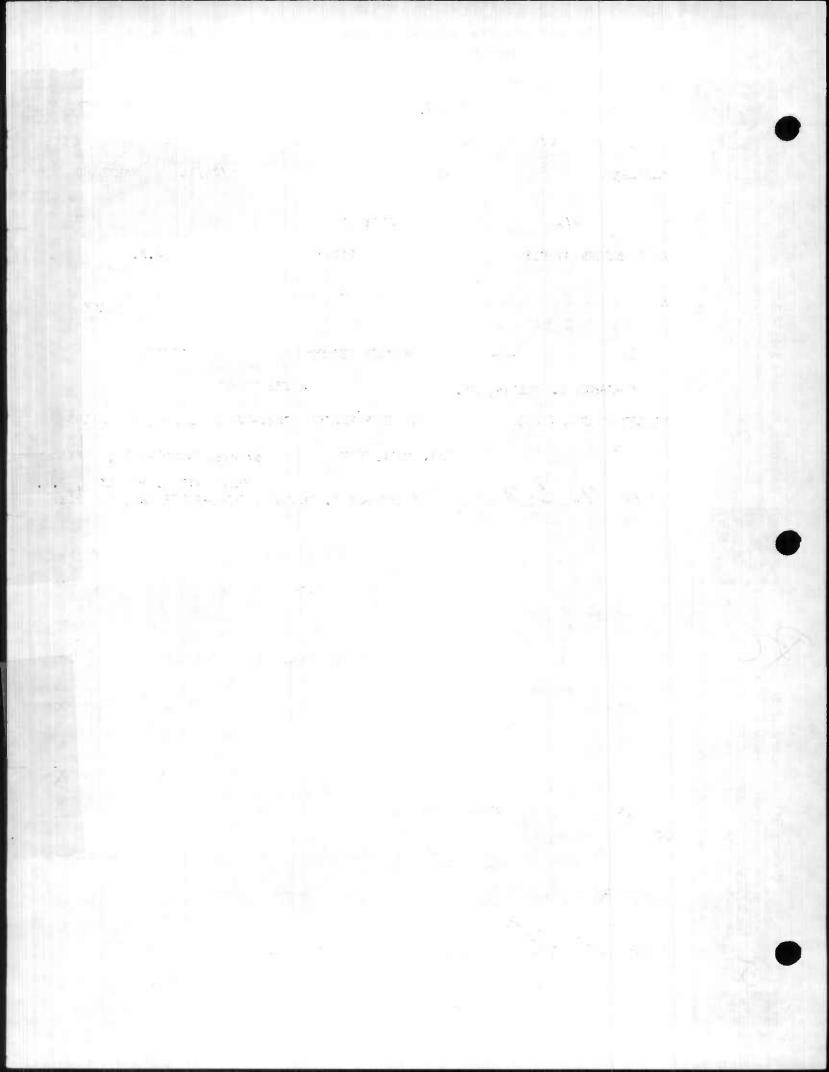


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 2 9 2 3 1 Certificate of Death Reg. No. 2. Date of Death Month Day Year 3. Time of Death

					Cer	tificate o	f Death		Reg. No.	(2601				
		1. Decedent's Name (First, Middle,	Last)					2. Date of De		Year	3. Time of Death				
	Physician /Medical	BENJAMIN	H	CORB:	IN			09	21	98	7:59 AM				
	Examiner	4a Facility Name (If not institution,		ber)	4		4b. City, Town, or L	ocation of Deat	h 4c. County	of Death					
		BALTIMORE	VA ME	DICAL	CENT		BALTER			MORE	CITY				
	Funeral Director	5. Sociel Security Number 216-01-4570 Usual Residence of Decedent	3. Sex 7. 1 € M 2 □ F	Age (In yrs. la 82	st birthday) Yrs.	if Under 1 Year Months Dey		8. Date of Bir (Month, De 8/24)	oy, Year)	9. Birthple Count MARYL	ace (State or Foreign (Y) AND				
	ahow ahow	10a. State 10b. County		10c. City,	Town or Lo	cation		-	196-	10	d. Inside City Limits				
	ath with the Maryla 23a or 28a-f ahor unit be notified a rai Director	MD N/A	1		BA	LTIMORE					1 X Yes 2 No				
	or 2	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Count	ry?				
	23a za	1324 MOSHER ST	TREET			212			U.S						
21215-0020	172 hours after death with the Maryland **natural**, or terms 23a or 28a-f ahow fidial Examinat must be notified at leted by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	12. Wes Decedd Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? ②No		Vas Decedent o Yes, specify Cu ☐ Yes 2 N	f Hispanic Origin? (Spuban, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specify	e - America ck, White, e	tc.				
5-0	72 ho	15. Decedent's	Education		16a. Deced	ent's Usual Occ	supation ne during most of work	eina.	16b. Kind of Bu						
21	c	(Specify only highest Elementary/Secondary (0-12)	College (1-4	lor 5+)	life. L	O NOT use reti	ired)	(III)							
	should be filed within and Mental Hygiene. marked other than imetic event, the M	10	-0-		MERCH	ANT SEA	7		SAILIN	-	HE SA				
Maryland	Tal Hy	17. Father's Name (First, Middle, La	ist)				18. Mother's Nam		, Maiden Suman	10)					
yla	Mental Mental Mental of stice every To Be	BENJAMIN H	. CORBIN,	SR.			HATTIE N	1ASON							
Nar	2 2 2 2	19a. Informant's Name/Relationshi					et and Number or Ru				Code)				
-	Health F Health Tem 27 other tr	RODNEY CORBIN	(SON)	and the			DOW COURT-		-		1133				
Ore	T tof H	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3	☐Removal from St	ate cer	metery, crem	sition (Name of natory or other p		Date	20c. Location -						
Em	Pa Int:	4 Donation 5 Other (Spe	cify)	METH	RO CRE	MATORY	9	/26/98	CATONSVI	LLE,	MARYLAND				
Baltimore	permit. Pa Departmen Important: eny Injury pnce.	21. Signature of Funeral Service Li	F. Hei	toCF	- 4	21-27 N	ress of Facility MONROE S				PS, P.A. 21217				
	Physician	23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause on each	used the deeth. ch line.	Do not ente	er the mode of d	lylng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset end Death				
1	/Medical Examiner	tmmediate Cause (Final disease or condition resulting in deeth) DYS ICHYTHMIA Due to (or as e consequence of):													
-	n and al-transit		b	MULT:	I-OR	GAN 54	STEM FAI	EWRE			6 DAYS				
ď	n and lai-tra	Sequentially list conditions, if any, leading to immediate cause. Enter UnderlyIng Cause (Disease or Injury			as a conseq						- h				
100	S S	that initiated events	с		140 PA					-	7 DAYS				
28	p physical as the tu	Due to (or as a consequence of): ABDOMTNAL AORTEC ANEURYM REPAIR									7 000				
Box	attenda for use		■ d	TIBLO	C ANEUPYS	m KE	PAIN		7 DAYS						
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Vital Records,	The law requires that sate has been signed page 2 should be de Completed by F						9.45	24a. Was	s an eutopsy ormed?	ava	re autopsy findings illable prior to npletion of cause leath?				
Re	The lay	Series I.						10	Yes 2 No		Yes 2 No				
Ial		25. Was case referred to medical					26. Place of Dea				7105 22(110				
5	hysician his certifi i director To Be	exeminer?	Hospital:	patient 2 T F	R/Outpatien	3□ DOA	Tthor:		Idenca 6 □Oth	er (Snecify)				
		27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Dete of (Month,		28b. Time of Injury	28c. In			how injury occur						
Divisi	tal or Attending P rs after death. si Director: Atter led in by the tuner certification:	3 Suicide 6 Could no 4 Homicide determin	and Zee. Plece of	f Injury - At hom , etc. (Specify)	ne, ferm, stre	et, factory, office	ce	28f. Location City or To	(Street end Numb wn, Stete)	per or Rura	Route Number,				
	To the Hospital within 24 hours a To the Funeral Completely filled Medical Ce	29a. Certifier Certifying (Check only one)	Physician: To the beaminer: On the basis and manne	is of examination	ledge, death on and/or inv	occurred at the estigation, in my	time, date and placa y opinion, death occur	, and due to the rred at the time,	cause(s) and ma date and placa,	anner as st end due to	ated. the cause(s)				
	Within To th	29b. Signature and Tille of Certains	111			29c. Lice	ense number		29d. Date signe	d (Month, L	Dey, Year)				
	12 (C118/0))	1/1/1/	14.	mn		F	- 11195		9/2	1/99	}				
	5	30. Name and address of person wi	no completed cause	of death (Item 2	23a) (Type, I	-	11110		119	110					
	2	MICHAEL P	ALFSE		BALTE		VA MET	TCAL I	COVTER						
		31 Date filed (Month Day Year)	32 Box	istrar's Slonatu			- 1 - 1 - 6 - [1000	101						

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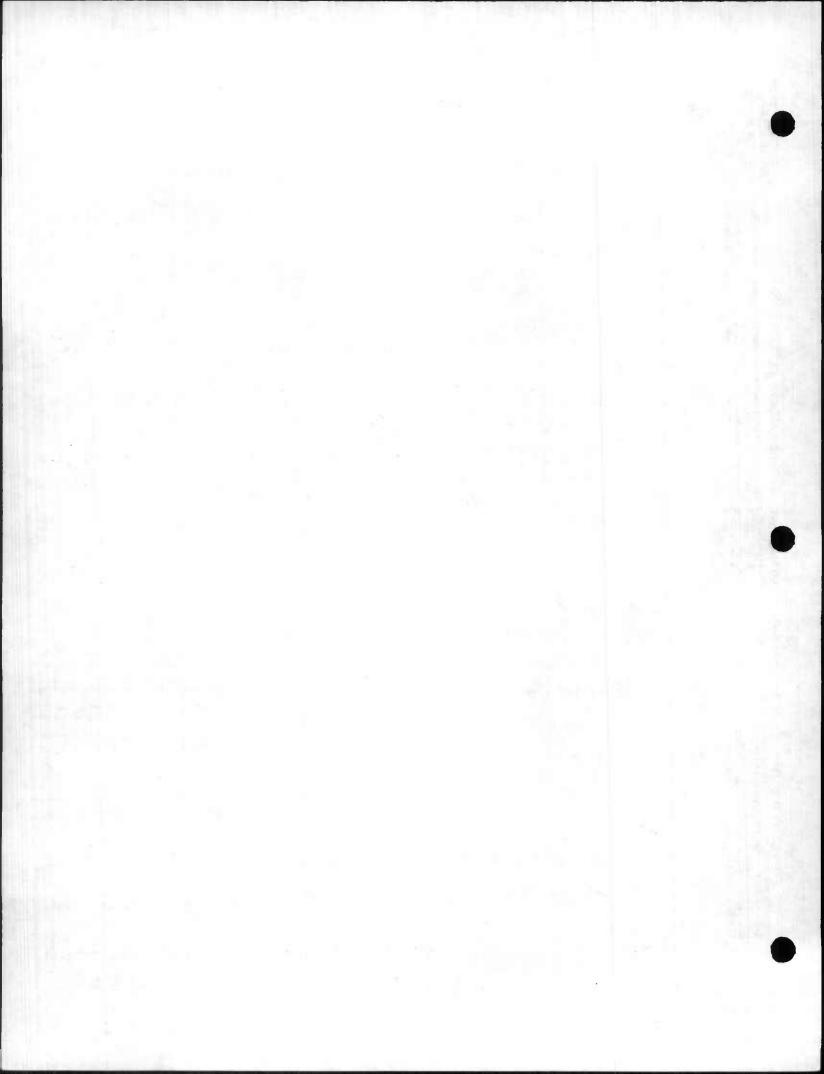
Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Dev **Physician** Month Year James Dotson September 20 1998 10:00 A.M. /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 436 E. Patapsco Avenue Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1MM 2□ F 217 50 9454 50 Director March 8, 1948 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1X Yes 2 No Director Maryland N/A Baltimore with tha 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 436 E. Patapsco Avenue 21225 U.S. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. filed within 72 hours efter I ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Sec 8th //Secondery (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Health and Mental Hygien Important: if item 27 Ia marked other that any Injury or other traumatic evant, the 2006. Construction worker Siding & Windows 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Walter Dotson Donna Pote 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Donna Fonte mother 4108 Doris Avenue Baltimore, Maryland 21225 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 9/23/98 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. manuau 4001 Ritchie Highway Baltimore, Md. 21225 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tntervel Between Onset end Death Physician tmmediete Ceuse (Final diseese or condition resulting in deeth) /Medical Cances Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical the Due to (or as a consequence of): P.O. the be Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? been signed by t should be detach 1 700 2□ No 3 Probably 4 ☐ Unknown Records, à 24b. Were autopsy findings available prior to Be Completed 24e. Was an autopsy completion of cause of death? pege 2 1 Yes 2 No 1 Yes 2 NO certificata Division of Vital Hospital or Attanding Physician: 24 hours after death.

Funeral Director: After this certifica director, 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how trijury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours after Funeral Dire detely filled in b 29a. Certifier Medical 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and mennar as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) E. Fort MD Kobert Dart 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State SEP 24 1998 Registrar

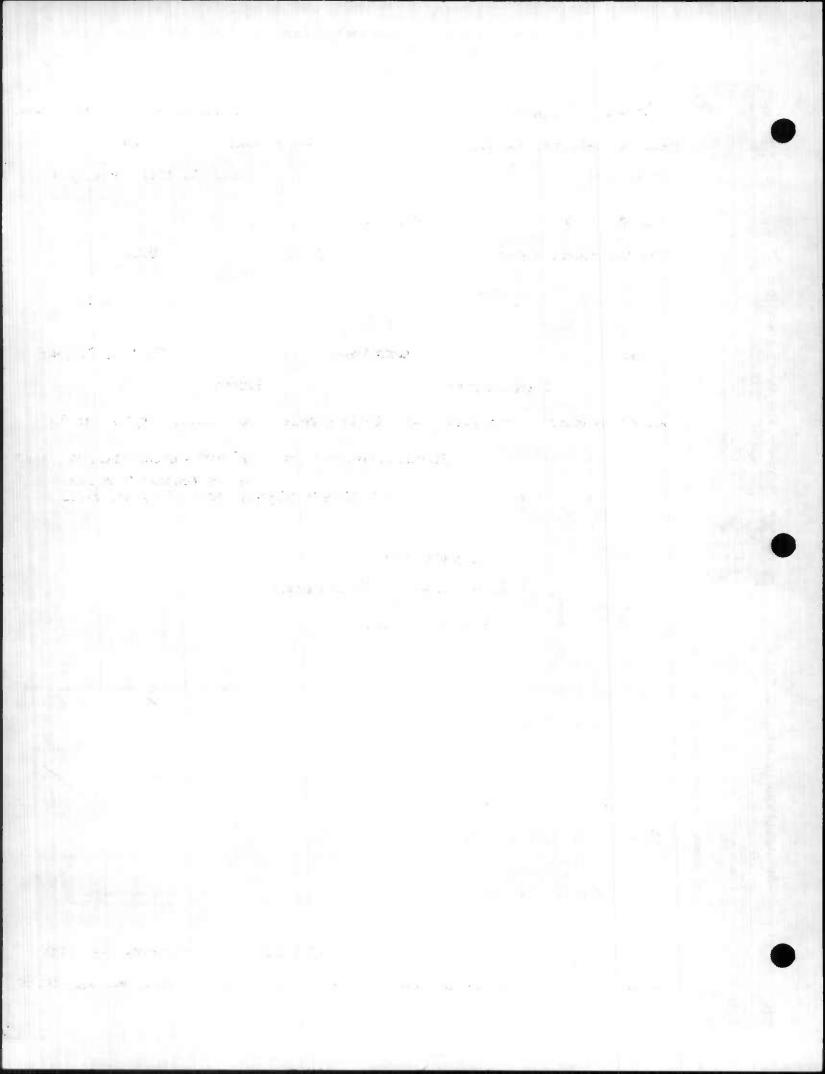


State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2 Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Dey **Physician** 21 VIOLET DASHIELL SEPTEMBER 1998 6:00 a.m /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) Funeral 1 □ M 218 F Months Deys Hours Min. 87 Yrs. Director 213 18 5191 July 25, 1911 Maryland Usuel Residence of Decedent the Manyland 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No N/A Baltimore Directo Maryland 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? ò 21225 3736 St. Victor Street U.S. "natural", or itsme 23a death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: by White 3√ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use ratired) permit. Pages 1 and 2 should be filed within: Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Company 6th 18 Mother's Name (First Middle Meiden Sumame 17. Fether's Neme (First, Middle, Last) Be Florence Collier Clarence Tarr 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 4215 Doris Avenue Baltimore, Maryland 21225 Norma Thornbury daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) injury or 9/24/98 Stevensville, Maryland Stevensville Cemetery 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility any ir Gonce Funeral Home P.A. ramusungu 4001 Ritchie Highway Baltimore, Md. 21225 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical YMP HO MA **Examiner** Due to (or es a consequence of) Examiner THROM BOSIS VEW Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760 HYPONATREMIA The law requires that the death certificate to Physician/Medical attending physical Due to (or es e consequence of): 23b. Did tobacco use contributa to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records, þ 90 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? peed has page 2 1 Yes 22 No 21 No 1 Yes certificata Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Dey Year) funeral 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 24 hours after death. Funeral Director: After 5 Pending investigation 1 Naturel or Attending 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 29e. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated. edicai completely 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. (Check only one) within 2 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 0 SEPTEMBER 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) HARBOR HOSPITAL CENTER, BALTIMORE 21225 Avinasa STREET, 3001 SOUTH HANDVER L. GANTL 31. Dete filed (Month, Dey, Year) 32. Régistrar's Signeture

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State Registrar

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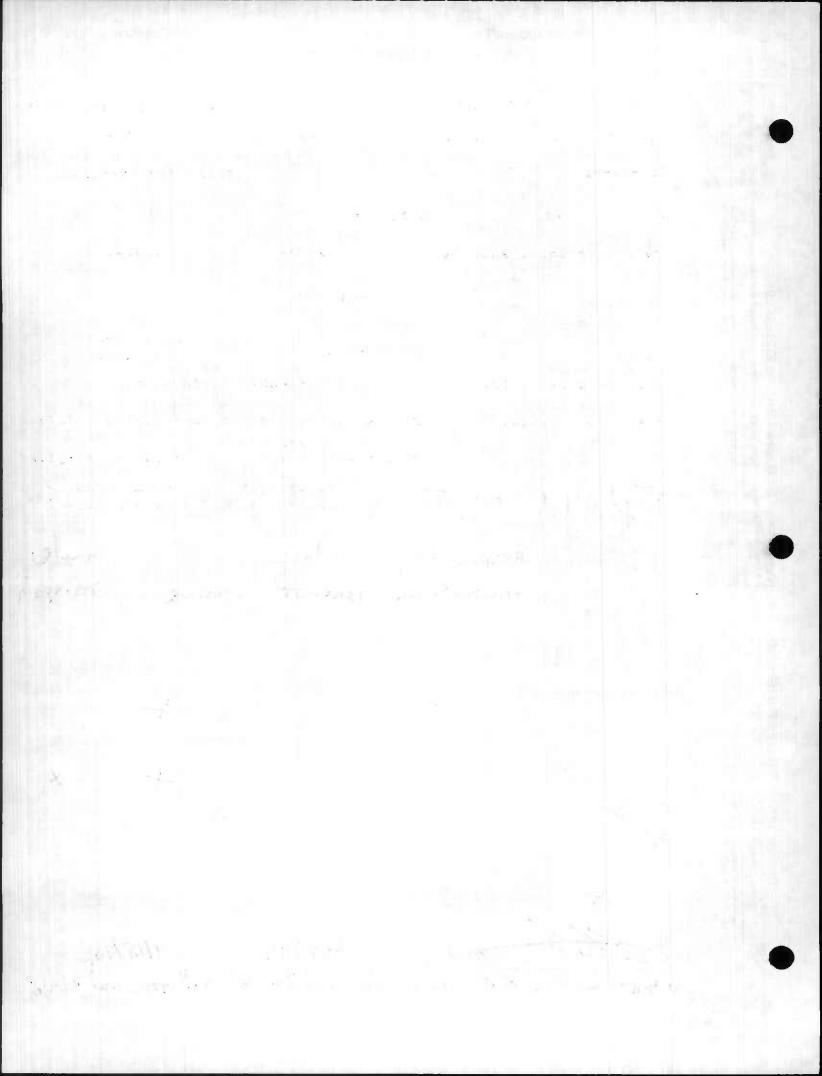


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DELORES DEBORAH DAVIS 15,1998 10:40p September /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** 4901 York Road, Apt. Al (res.) Baltimore If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days 1 ☐ M 258 F 213-52-4699 48 Director 11/27/1949 Maryland Usual Residence of Decedent with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. inside City Limits if than "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at MD N/A Baltimore 1 Vas 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? TO 4901 York Road, Apt. Al 21221 U.S.A. Funeral daath 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Datas: 1 ☐ Naver Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Johns Hopkins Elementery/Secondery (0-12) College (1-4or 5+) Hygiana. X-Ray Clerk 12th Hospital id 2 should be filed the and Mental Hygie 27 is marked other traumatic event. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Clarence Booker, Sedonia Livingston 19e. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pagas 1 and 2 permit. Pagas 1 and 2 Department of Haalth as Important: if Item 27 is any Injury or other tracence. Linwood Davis, Jr. 726 Cumberland Street, Balto., MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 9/21/98 Date 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park Arbutus, Maryland 21. Signature of Funeral Service Licent 22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 ions that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, En er the diseas or heart failure. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . Respirator-Examiner Due to (or as a consequence of): Examiner metalatic BREAST CANCER physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last Due to (or as a consequence of) cartificata be axec Box 68760. Physician/Medical Dua to (or as a consequence of): 88 usa Ö Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? datached signed by t 1 Yee No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to 24e. Wes en autopsy performed? Completed peen completion of causa of deeth? has paga 2 cartificata Vital Attending Physician: director Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)
njury at 28d. Describe how injury occurred Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yas 3 No Divisionof 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation 2 Accident 1 Yes 2 No after daat Directer: 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 24 hours a Funerel D The contifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piace, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune complately fi (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) m.0 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) WAlter menor. m +0. 4200 Pay Year) 1998 32. Registrar's Signatura State

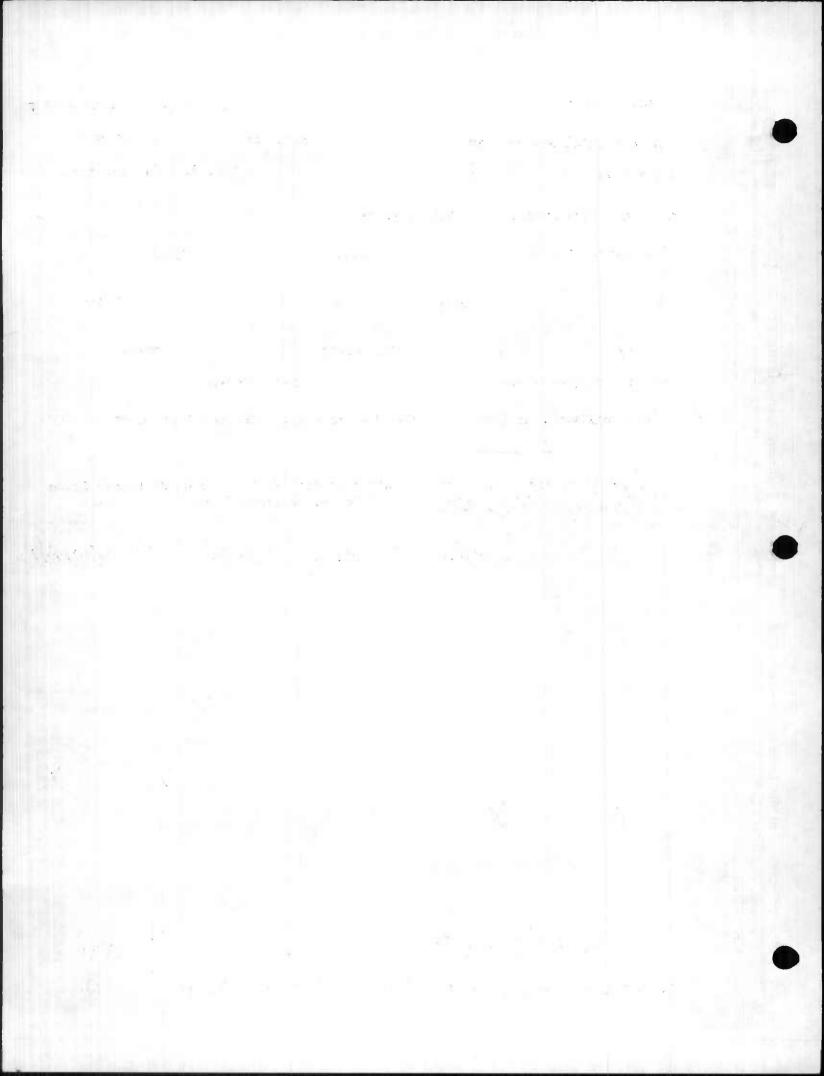
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State of Maryland / Department of Health and Mental Hygiene 98

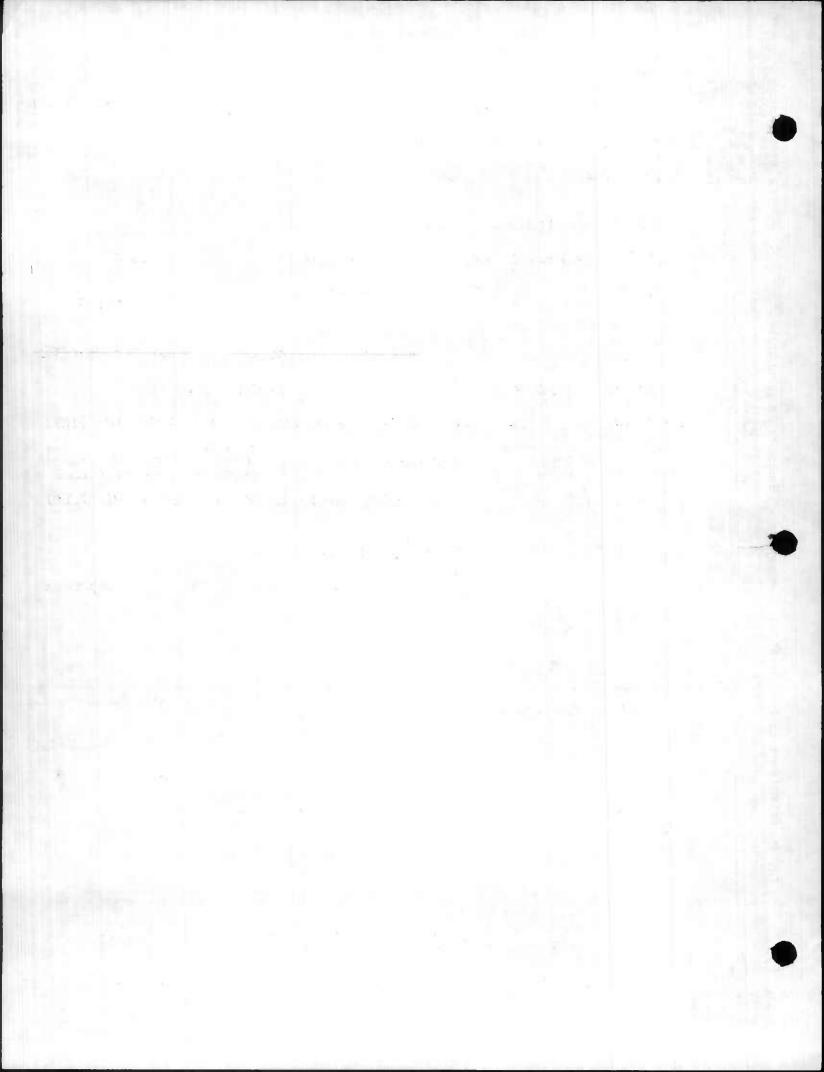
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Examiner	4a Facility Name (If not institution Anne Arundel						b. City, To Annap		ocation of Deat		of Death Arun	del	
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To the Hospital or Attending thin 24 hours after death. To the Funeral Director: A completaly filled in by the family Medical Certificati	29a. Certifier 1 Certifyir	ng Physician: To the b	pest of my knowl										
To the Complete Complete	296. Signature and title of settille	and manne	er stated.		290 L	icense	number	4		29d. Date sign	ed (Month,	, Day, Year)	
State Registrar	30. Name and address of parson Potter X. 31. Data filed (Month, Day, Year) SEP 2 4 19		of deeth (Item 2 AUXE gistrar's Signatu	ARU	Print Ul	1k	led.	Ote-	- Aura	polis	m	d	



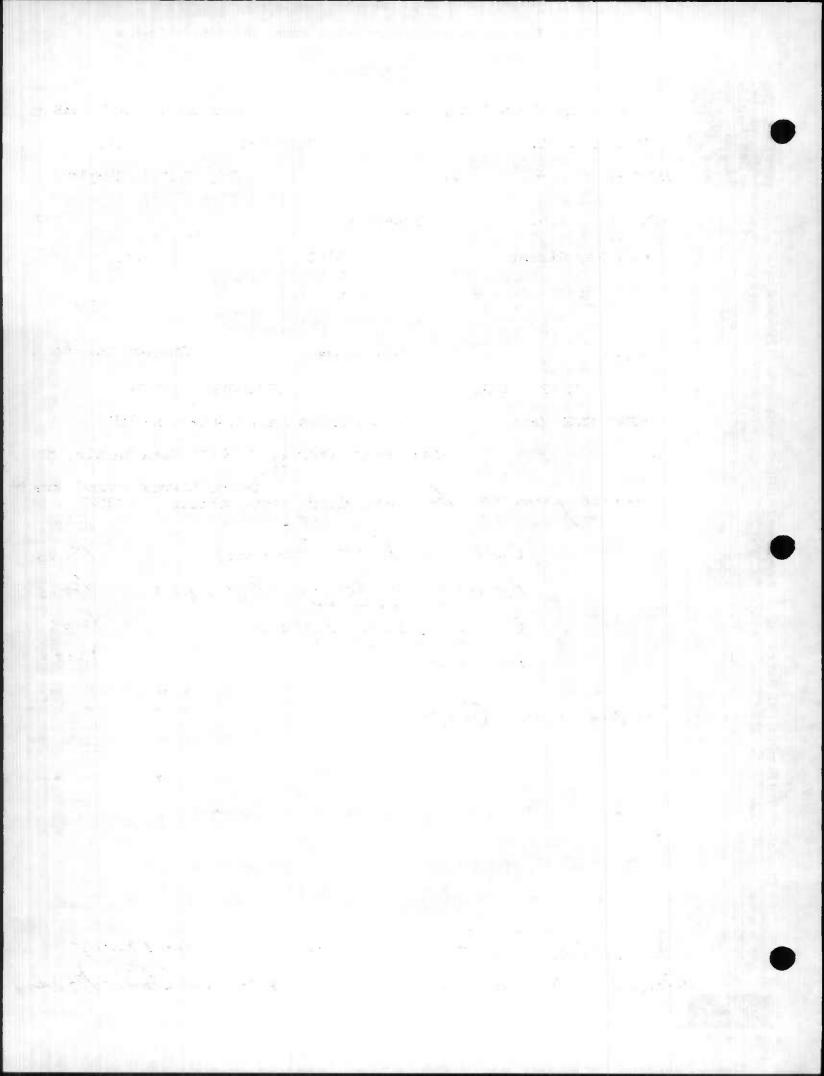
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miner	4e Facility Neme (If not institution, giv	e street end number)			4b. City, Town, or L	ocation of Death	4c. County	of Deeth	
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eral	5. Social Security Number 6. S	PM 2 F 7. Age (In	yrs. lest birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthpl Count	lace (State or Foreign try)
tor	Usuel Residence of Decedant		53			AUG. 19	3,1910		VA.
Director	10a. State 10b. County	10	c. City, Town or L	ocation				10	Dd. Inside City Limits
ō	MD BALT	THORE	CUB H	lan i					1 ☐ Yes 2 ☐ No
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	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plicetions that caused the one cause on each line.	death. Do not er	ntar tha mode of dyi	ng, such es cardiec	or respiratory a	rrast,		Approximata Intervel Between Onsat and Deeth
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	Part fl. Other significant conditions of	ontributing to death but no	ot resulting in the	underlying cause gi	ven in Part I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
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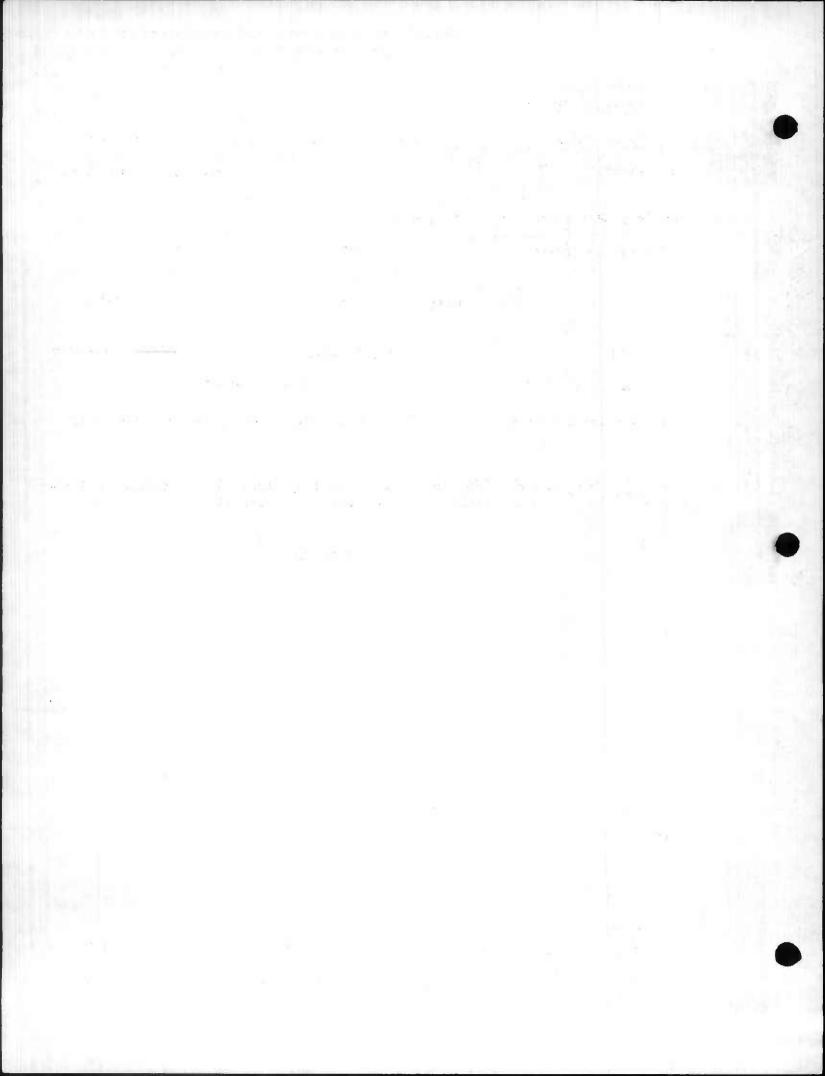


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Cartificate of Death						

December States Prival Claim HERBERT JAMES GRAY SR. School September 16, 1988 10:45 cm 10:45							Ce	ertifica	te of	Death			Reg. No.			
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 29b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknow 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy indings available prior to completion of causa of death? 25b. Was case rafarrad to medical examiner? ô	tendi r us			0	100	3401										
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30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Owner Ress, 190 Suggested 200//ossagge Dear Granburger/Varyen		5	30. Name and address of p	erson who o	completed cause of	death (Item	23a) (Typ	e, Print)	1		~	/	210	6/	4	
Works Kiss, MD Sugar SOU 2001/8500 Chair Ocea Bungo / yryes			Wares Res:	17	D Sugg	E SOL	1 00	00/1	250	245	pho	ur O	cenbu	2047	1 yryes	4
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6b Per A					9-24-98R0		nd / Depa <i>Cei</i>			Death			giene 9 Reg. No.	0 4	9238
Physician /Medical			e (First, Mide P. Go1									2. Date of De Month POTEMPE	Dev	Year 998	3. Time of Deeth
Examiner uneral rector	5. Soci	R 4 A B Security N 7 - 12 - 9	Ind C	7 <i>em</i>	eroet and num	HOSP 7. Age (In yrs. 77	rtal lest birthday) Yrs.	If Unde	r 1 Year	lb. City, Tov Received the Control of Under 2 Hours	MORE Min.	ation of Deat B. Date of Bir (Month, Da March	Balt	imore 9. Birthpla Countr	City ce (State or Foreign) land
show od as	10a. St	300	10b. Count	,			y, Town or Lo				1				d. Inside City Limit
Directo	10e. St	yland reet and Nur 12 Bo			e City	Bal	ltimore	10f. Zip	Code 1217		-		10g. Citizen of V		1 √ Yes 2 □ N
er, or items 23a Examiner must by Funeral	11. Mai	ital Stetus Never Marri	ed 2∏xMa	urried	12. Was Dece Armed For 1 7 Yes if Yes, Give Yeer or Da	ces? 2 No		Was Dece f Yes, spe	cify Cuba	ispenic Origin, Mexican,	in? (Spec Puerto R	ify Yes or No icen, etc.)	- 14. Rac	e - Americar ck, White, et	C.
dedical pleted		(Spec	15. Decede ify only high ndery (0-12)	nt's Educ est grade			16a. Deced (Give life. L	lent's Usu kind of wo DO NOT u	ork done d ise retired	duning most ()	of working		16b. Kind of Bi RUBBER -Rubbe		stry
To Be		Morto	(First, Middle n M. G	olds						Sopl	nie P	utzel	Maiden Suman		
imporant, it tent of its marked other than any injury or other traumatic event, that had one. To Be Com	20a. Me	ally (ethod of Disp Burial 2	Cremation	ith/				Bolt	ton S	Street			e, Maryla 20c. Location	and 21	217
eny injury	1	•	5 Other (Wade	Direct						i, 655	W. Balt	imore	Street
burial-transit and principles at Examiner	Immed diseas resultin Sequer if any, cause. Cause	iate Cause (e or condition in deeth) Initially list conteading to im Enter Unde	Final n nditions, mediate rhying injury	st only on	cations that cale cause on ea	Due to (c		uence of):					1001;	; 1	oproximate nterval Between Onset end Deeth
by the attending physical sched for use as the but hysician/Medical	resultin	g in death) l	Lest	ions con	I		r as a consequence of as a consequence of a consequence o		cause give	en in Part I.			tobacco use co Yes 2□ No	ntribute to t	he cause of death
should be d												perto	en eutopsy rmed?	avail com of de	
To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh Medical Certification: To Be Comple	27. Mer	Antural 5 ☐ Pending (Month, Dey Year) Inju			28b. Time of Injury	tpatient 3 DOA Other: 4 Nursing Home 5 Firms of hiury M 28c. Injury at Work? M 1 Yes 2 No				(Check only of the State of the	1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No k only one) ☐ Residence 6 ☐ Other (Specify) scribe how injury occurred				
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200	29b. Signature and Hills of certifier 29c. License number 29d. Date signed (Month, Despecially 198) 29c. License number 29d. Date signed (Month, Despecially 198) 29d. Date signed (Month, Despecially 198) 29d. Date signed (Month, Despecially 198) 29d. Date signed (Month, Despecially 198) 29d. Date signed (Month, Despecially 198) 29d. Date signed (Month, Despecially 198) 29d. Date signed (Month, Despecially 198) 29d. Date signed (Month, Despecially 198) 29d. Date signed (Month, Despecially 198) 29d. Date signed (Month, Despecially 198) 29d. Date signed (Month, Despecially 198) 29d. Date signed (Month, Despecially 198)								ey, Yeer)						

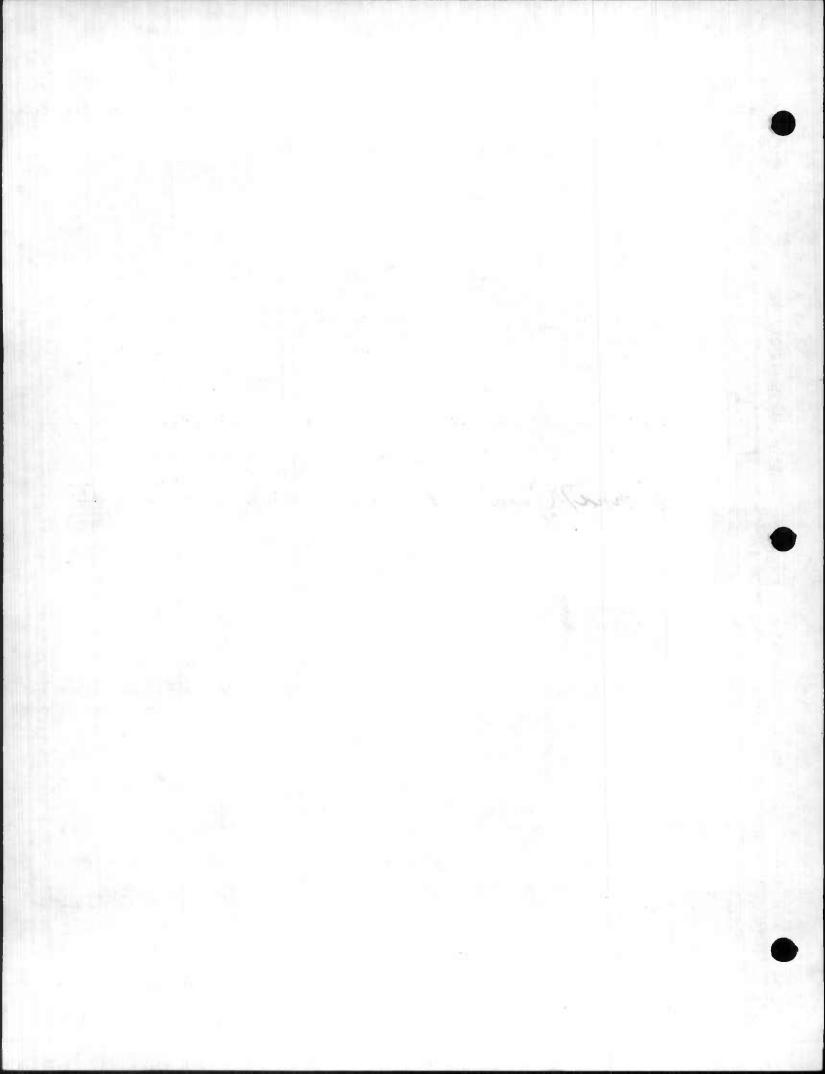


State of Maryland / Department of Health and Mental Hygiene

						Certifica		Death		Reg. No.	29239
П	Physici	an	1. Decedent's Nema (First, Middla, Last						2. Dete of Da Month	Dev	3. Time of Deeth
	/Medio		4a. Facility Neme (If not institution, giva	street and number)	~			4b. City, Town, or	Septem Location of Deeth	4c. County o	198 0 PM
1	Examir	ier	Mariner o	0 0	Burn	100		01 0	urnie	0	Arundel
	Funeral Director		5. Sociel Security Number 6. Sa 220 30 0825		(In yrs. lest bi		dar 1 Yaar ns Deys	If Undar 24 Hrs	8. Dete of Bir (Month, De	h y, Yeer)	9. Birthpiece (Steta or Foreign Country) Maryland
	and		Usuel Residence of Decedent 10e. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
	Mary H sh	tor	Maryland N/A		Balti	more					1⊠Yes 2□No
	or 28s	Director	10e. Street and Numbar			10f.	Zip Code			10g. Citizen of Wi	nat Country?
	23a and based		4823 Pennington A				2122	6		U.S.	
21215-0020	n 72 hours after death with the Maryland "natural", or items 23s or 28s-1 show sides Exacanet must be notified at	by Funeral	11. Marital Stalus 1 □ Naver Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedant E Armed Forces? 1 ☐ Yas 2 ☒ N If Yes, Give Yaar or Dates:				Hispenic Origin? (Seen, Mexican, Puer Specify:	Specify Yes or No to Ricen, etc.)	14. Race Bleck Specify:	- American Indian, , White, etc. White
5-0	72 ho netur	eted	15. Decedent's Edu (Specify only highest grad		18a	Decedent's U	suel Occup work done	petion during most of wo	rkina	16b. Kind of Bus	iness/industry
121	- pr - mil	Completed	Eiementery/Secondery (0-12)	Collega (1-4or 5-	+)	Office:		during most of wo		Dona 1	Cristian
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Maryland	12 should h end Men 7 is marke traumatic		19e. Informent's Neme/Ralationship (T)					end Number or Ri			
	C # 2 -		Charlotte Hurman	/ daughte				on Avenu			Maryland 21226
altimore,	S 7 2 0		20e. Method of Disposition 1 Buriei 2 □ Cremetion 3 □ F			f Disposition (fing), cremetory of			Dete		city or Town, Steta
Itin	in in it		4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funerel Sarvice Licens		HOTA (Cross C		ery ess of Fecility	9/26/98		re, Maryland
B	Deperture once		10- m	2 :	- 6	7		ie Highw		uneral H	
			23a. Part . Enter the disease, or con- shock, or haart failura. List only o	lions that caused	the deeth. Do						Approximete
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	/Medical Examiner		Immedieta Ceuse (Finai diseese or condition rasulting in deeth)	ALZHE	IME	25	NEI	MENTI	A		5 YEARS
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68760	g physic as the b	edical	Cause (Diseasa or injury thet initieted evants rasulting in deeth) Lest	3C	Dua to (or es e	consequance o	of):				
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Box	death cert e ettendin od for use	Iciar	Pert II. Other significant conditions con	ntributing to death bu	t not reculting t	n the underbule	a cours air	voe in Post I	22b Did	lohacoo uaa cont	whyte to the cause of death?
, P.O.	requires thet the death cer seen signed by the ettendir hould be detached for use	by Physician/N	Parti. Other significant conditions co.	ithouting to death ou	t not resulting i	n the undanying	g cause gr	ven in Pert I.	1 🗆		ribute to the cause of death? 3 Probably 4 Unknown
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Vital		Be	25. Wes case referred to medical exeminer?					- 4	ath (Check only o	ona)	
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uo	the factor	tlon	1 ⊠Naturel 5 ☐ Panding	28a. Data of Injury (Month, Dey	Yeer) 280.	Time of Injury M	28c. Inju Wo	ryet rk? Yes 2□No	280. Describe	now Injury occurre	d
Division of	Attending ir death. actor: After by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be datarmined	28e. Piace of Inju	ry - At home, fe						r or Rurei Route Number,
ā	tal or rs efte al Dir	Cert	4 Homicide	building, etc.	. (Ѕресігу)				City or To	vn, Stete)	
	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	edical	Check only 2 Medical Exami	sician: To the best of nar: On the besis of	axamination ar	a, daath occurre	ed et the ti	me, dete end piece	e, end due to the urred et the tima.	ceuse(s) end men data and place, er	ner es steted. nd due to tha cause(s)
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	d		30. Name and eddrass of person who co	ompiated causa of da	HULA I	(Type, Print)	4710	PENN	VINGTO	N AV	ENUE
	0		30. Name and addrass of person who co USHA SRIMARI VE	MULAKON	IDA	BAL	TIN	ORE.	MD,	2/22	-6
	Sta Registr	ite	31. Date filed (Month, Day, Year) SEP 2 4 1998	32 Registre	r's Signeture	9. do	ack	/	,		



A	mended I	ten	d#5 perVSG788 10/10/200	State of	f Marylar		artment rtificate			ind M	lental Hyg	iene g	8 2	9240
	6		1. Decedent's Name (First, Middle, La	st)							2. Date of Deal	th Day	Year	3. Time of Death
G.	Physici: /Medic			Inse	ok Ha	n					Septembe		1998	8:15 P.M.
	Examin		4a Facility Name (If not institution, given	re street and nur	nber)			- 4	4b. City, Tov	wn, or Lo	cation of Death	4c. Coun	ty of Death	
			2723 Wilkins A	venue					Balt:		е	N/2	A	
	Funeral		5. Social Security Number 0814 6. S	Sex I□M 25XIF	7. Age (In yrs.		If Under Months	1 Year Days	If Under 2	Min.	6. Date of Birth (Month, Day)	Year)	9. Birthp	lace (Stete or Foreign try)
	Director		213 /0 - 1041	IUM ZAJF	68	Yrs.					June 8,	1930		orea
	D		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation						1	Od. Inside City Limits
	ranyan ranyan	0	Maryland N/A		Ba	altimor	e							1⊠ Yes 2□ No
	a or 28a-f	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Coun	trv?
1	23a or		2723 Wilkens Ave	enue				212	23			U.		
	nours and death with the Maryland turel, or flems 23s or 28s-f show al Exeminer must be notified at	Funeral	11. Marital Status	12. Was Dece		J,S. 13.	Was Deced			gin? (Spe	ecity Yes or No- Rican, etc.)	14. Ra	ce - Americ	
0	100		1 Never Married 2 Married	Armed For	2X No					, Puerto	Rican, etc.)		ack, White,	etc.
213-0020	The same	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Giv Year or Da			1□ Yes 2	IN NO	Specify:			Speci	y: Wh	ite
6	natural,	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	dent's Usue	k done	during most	of worki	ing	16b. Kind of I	Business/Inc	lustry
171	within 72 and. than na	du	Elementary/Secondary (0-12)	College (1	-4or 5+)		<i>po not</i> us nemake		d)			0	Ilomo	
	H Service	ပ္	8th			1101	iemake	T	10 Matha	do Momo	(First, Middle, I		1 Home	
	a do de	Be	17. Father's Name (First, Middle, Last	lojun Ha	n				TO, MOUTE		n Nan Ch		ille)	
	d Me d Me d Me d Me	2	19a. Informant's Name/Relationship (-	11	10b Maili	na Addense	(Street	and Numbe		Il Route Number		Clata 7in	Codel
3	7 5 2 3		Hisook Cipriano		ghter		Wilki							nd 21223
ш .	TREE		20a. Method of Disposition		20b.	Place of Dispo	sition (Nam	e of				20c. Location		
P :	V III		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif		Stelle	cemetery, creating 11top			-	9	/25/98	Tows	on. Ma	ryland
saitimore,	Department of Figure 1 Important: If Ita eny injury or of page.		21. Signature of Funeral Service Lice		1		2. Name and							-
Ď	A E S A		10 man TM	2	*	A: 40	001 Ri	+ch:	ie Wid		Gonce Fi y Balti			
			23 Pert1. Enter the disease, or pert shock, or heart failure. List only	pications that co	<i>INTILL</i> aused the dea						_		Mu. Z	Approximete
Р	hysician		shock, or heart failure. List only	one cause on e	ech line.								1	Interval Between Onset and Deeth
	/Medical		Immediate Cause (Finel disease or condition		neto	us fatil		22	1 (6	me	~		1	4 mose
ŧ	xaminer		resulting in death)	a		or as a conse) · (·	16					
3	2 %	100		h									i	
-	2 2	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or es e conse	quence of):						-	
6	No.	-	Cause (Disease or injury	c										
100	E =	900	that initiated events resulting in death) Last		Due to (d	or es a consec	juence of):						- 1	
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2	ch da	Physician/M	Part II. Other significant conditions of	ontributing to ge	ath but not res	suiting in the u	noenying ca	iuse giv	en in Part I.			a 2 No		the cause of death?
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Colds, T	d blu	8									24a. Wes a		24b. We	ere autopsy findings ailable prior to
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Bliv 10	~ ~ ~	2	1 Yes 2 No	Hospital: 1 Ir	npatient 2	ER/Outpatie	nt 3 DO	A Oth	er: 4 Nu	rsing Ho	me 5 Reside	ence 6 🗆 O	ther (Specif	y)
	ar deeth. ector: Aftar th by the funeral	- 1	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of (Mont)	of Injury h, Day Year)	28b. Time o	1 28	Bc. Injur Wor	y at k?		28d. Describe h	ow injury occu	erred	
0 8	deeth.	Cat	2 Accident investigation				М	10	Yes 2 n					
DIVISION	12-6	Certification:	3 Suicide 6 Could not b 4 Homicide determined	288. Place	of Injury - At h ng, etc. (Speci	nome, lerm, str ify)	reet, fectory,	office		1	28f. Location (Si City or Town		nber or Rura	I Route Number,
	2 0 E	0	50. 0. V.											
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4	within 24 hours after	Med	29b. Signature and title of certifier	and mann	er stated.	4	29c.	Licens	e number		2	9d. Date sign	ed (Month.	Day, Year)
	8 4 €		10				7	UA	050			Sant		22 1466
	1		30. Name and address of person who	completed co	Min of death (tree	m 23e\ /T	Print!	770	00			sepier	more,	26,1778
			TUONNE		WI HN	D MY	900	0	+TON	ANF	BALT	imare	· mo	21220
	Star	e	31. Date filed (Month, Day, Year)	32. Re	egistrar's Sign	eture		,	, ,	.,	1 101101			Day, Year) 22, 1998 21229
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Defe of Deeth 3. Time of Deeth Month **Physician** September Paul Joseph 5:25 Pm Hohman 12 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Union Memorial Hospital Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) 11XM 2□ F 219-18-5738 Yrs. 73 July 11, 1925 Maryland Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland N/A Baltimore 10e. Streef end Number 10f. Zip Code 10g. Citizen of Whet Country? 5424 Cedonia Avenue 21206 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Defes: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Mechanic Refrigeration 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Matthew Hohman Sophie McAllister 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr. John J. Hohman / Brother 2729 Pelham Avenue Baltimore, MD 21213 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stefe 4 ☐ Donelion 5 ☐ Other (Specify) 9/25/98 Baltimore, Maryland Holy Redeemer Cemetery 22. Name end Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 or complication, thet ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, ulst only one ceuse on each line. Approximete Intervel Between Onset end Deeth Pert1. Enter the dise shock, or heart tallur Immediate Ceuse (Finel disease or condition resulting in deeth) omonary Anterny Disease Due to (or es e consequence of): Depsis day Physician/Medical Examir Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Deep Venous MMombosis Due to (or es e consequence of): Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ¥ Yes 2 □ No 3 □ Probably 4 □ Unknown Cononary Anterny Bypars Surgery by 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1-typentension 1 Yes 2□ No 25. Wes cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturei 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, deeth occurred et fhe time, dete end plece, end due to the ceuse(s) end menner es steted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner stated. Issociate Patholosist 29c. License number 29d. Dete signed (Month, Day, Year)

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To the within 2 To the

Funeral

Director

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e filed within 72 hours efter death value Hygiene.
other than "natural", or items 23sent, the Wool of Examine must

permit. Pages 1 and 2 should be filed v Department of Health end Mental Hygie Important: If Item 27 Is marked other ut any Injury or other traumatic event, the

Physician

/Medical

Examiner

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LINDA D. 31. Dete filed (Month, Day, Yeer) SEP 2 4 1998

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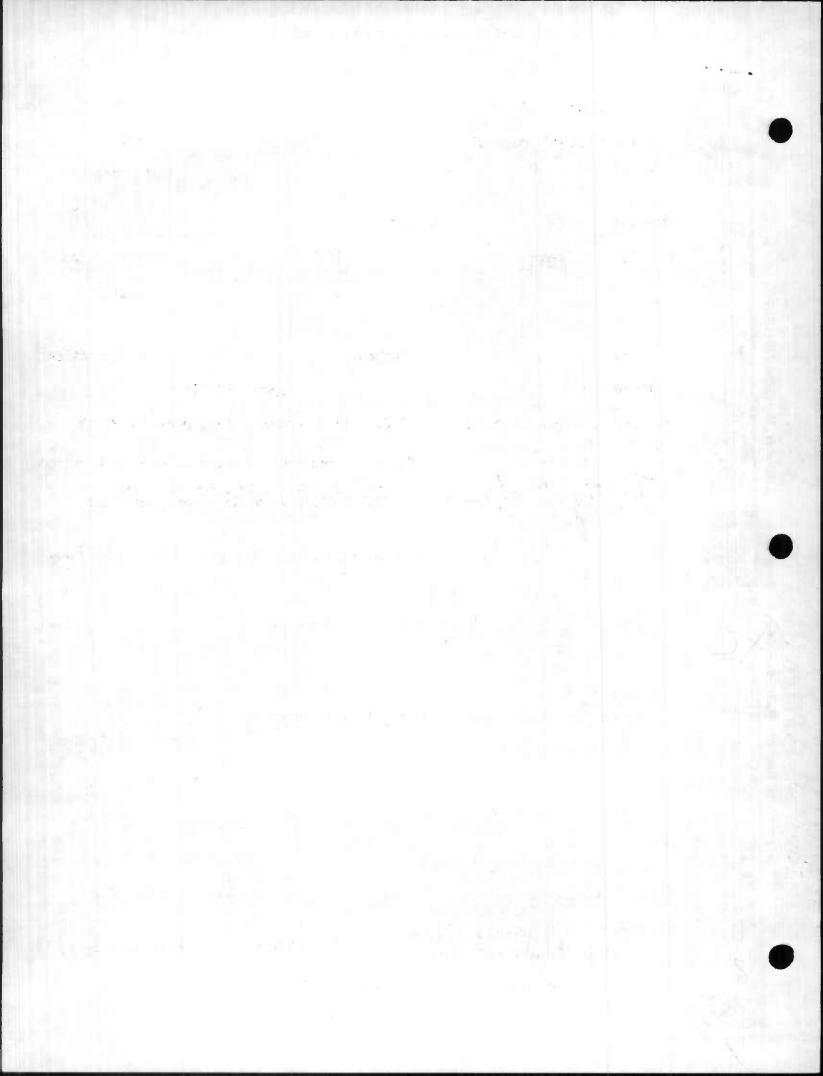
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BALTIMORE, IND 21218

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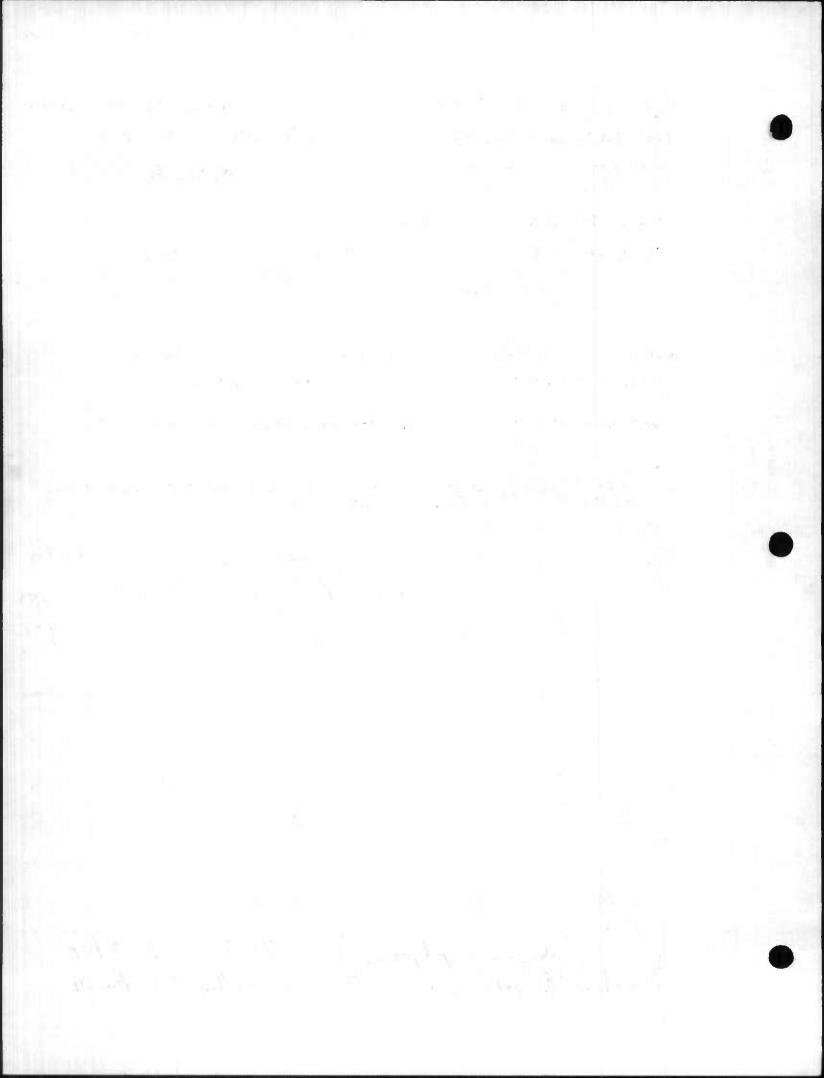
30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death r 11, 1998 Month **Physician** Hanline Agnes G. September 11:35 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore 8. Data of Birth (Month, Day, Year) Feb. 22, 1917 7. Age (In yrs. last birthdey) 81 Yrs. if Undar 1 Yeer If Under 24 Hrs. 5. Social Security Number Birthpiaca (Steta or Foreign Country) **Funeral** Days 1□M 2☑F 218-18-0025 Maryland Director Usual Rasidance of Dacedant 10a. Steta 10b. Count 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas 2 ☐ No Baltimore Director Maryland Catonsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? arked other than "natural", or items 23s or atic event, the Medical Examiner must be r 711 Academy Road 21228 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Bieck, Whita, etc. Pages 1 and 2 should be filled within 72 hours after nart of Health and Mental Hygiene.
Int. If item 27 is marked other than "natural", or its 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas: 1 T₹Never Merried 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Dacedant's Education ify only highest grade complated) 16b. Kind of Business/Industry (Specify only highest g Eiamentary/Secondery (0-12) Collaga (1-4or 5+) unknown unknown Homemaker Own Home 17. Father's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumema) Be Herman W. Kaiserski Antoinette B. Long 2 19a. informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Anne Weinkam/niece 311 Orley Road, Catonsville, Maryland 21228 20b. Piace of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removei from Stete Department or important: If i any injury or once. 8 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funaral Sarvice Licensee ROMAID S. Wade 22. Name and Addrass of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Director Relece 23a. Part I. Entar the disaese, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. Intervei Batween Onset end Deeth Physician /Medicai immediate Cause (Final disease or condition rasulting in death) Examiner Examiner physician and the burial-transit Sequentielly list conditions, if any, laeding to immadiata cause. Entar Underlying Cause (Disease or Injury that initiated avents rasulting in daeth) Last P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of) 88 use 10 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yea Division of Vital Records. by 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was en eutopsy performed? page 2 certificate has 1 ☐ Yes 2 ☐ No I or Attending Physician: aftar death.
Director: After this certifica 25. Was casa refarred to medical Be 26. Piaca of Death (Check only one) axaminar? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 0 funeral 28c. Injury at Work? 27. Menner of Death 28e. Data of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 1) Naturai 2 Accident 5 Pending invastigation 1 Yas 2 No 6 Could not be determined 3 Suicida To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 - Homicida Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piace, and due to the cause(s) and mannar as stated.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and piace, and due to the cause(s) and mennar stated. 29a. Certifier Medical (Check only one) 29b. Signature and tifle of certific 29d. Data signed (Month, Day, Year) 30. Neme end addrass of person who complated causa of death (Itam 23a) (Type, Print) hime Album 31. Date filed (Month, Day, Year) SEP 2 4 1998 32. Registrar's Signatura State

Registrar

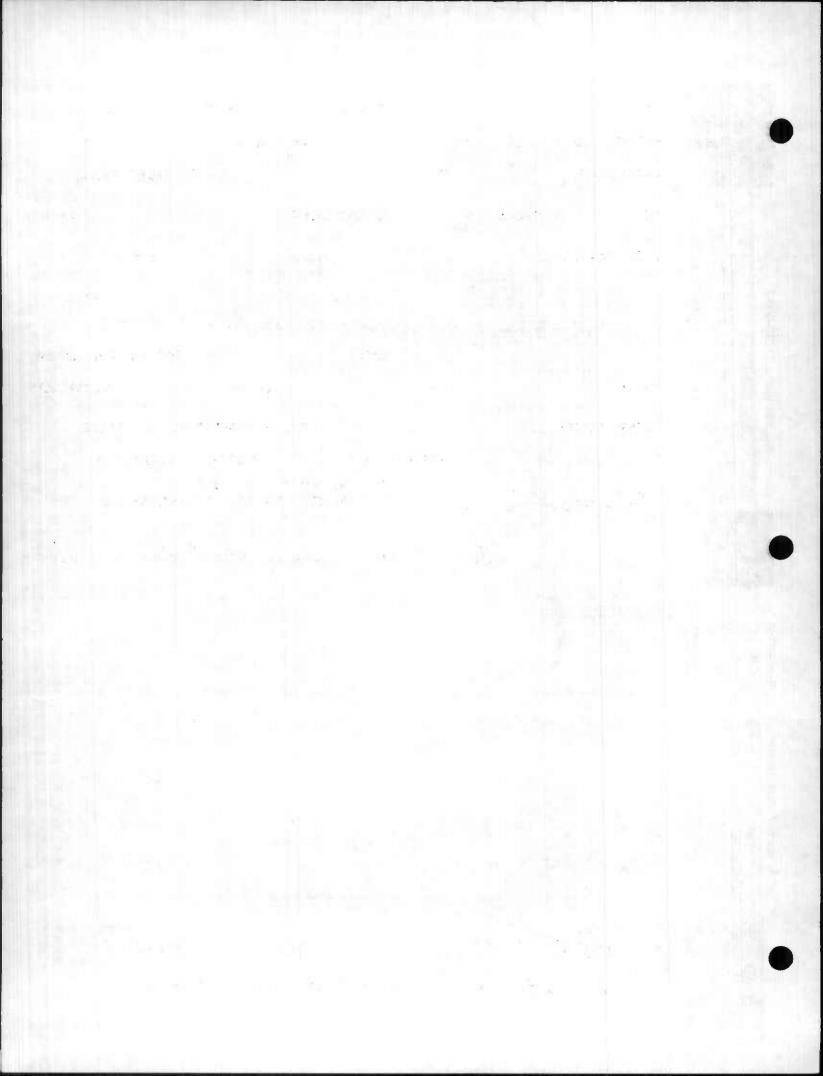


State of Maryland / Department of Health and Mental Hygiene:

Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:20 AM RAE HIRSCH SEPT 21 1998 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 5. Social Security Number if Under 1 Year if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours Yrs. 212-12-9491 88 Director JAN. 10 1910 POLAND Usual Residence of Decedent the Marylend 10a State 10h Counts 10c. City, Town or Location 10d. inside City Limits "natural", or items 23a or 28a-f ehow soical Examiner must be notified at MD BALTIMORE RANDALLSTOWN 1 TYPes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3937 SUSANNA RD. 21133 USA Funeral filed within 72 hours efter death Hygiene. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. 11. Maritai Status Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: WHITE þ 3 ☐ Widowed 4 ☑ Divorced the Medical Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed w
Department of Heelth and Mentel Hygien
Important: If frem 27 is marked other tha RETAIL DEPT. STORE SALES 18 Mother's Neme (First Middle Meiden Sumame) 17. Fether's Name (First, Middle, Last) CHAIM MONK BAILKE SHERKAINSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD HIRSCH (SON) 3937 SUSANNA RD. RANDALLSTOWN, MD 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State RADOMER VEREIN 9/23/98 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE, MD 21. Signeture of Funeral Servica Licansee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 were 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) vessel disease Examiner Due to (or as a consequence of): Examiner end Il-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 2 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed ils certificate has b director, page 2 s 1 Yes 2 0 No 1 ☐ Yes 2 ☐ No al or Attending Physician: Tis effer death.

I Director: After this certificated in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury at Work? Certification: 27. Manner of Deeth Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide • Funerel Di Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) end menner stated. 29a. Certifier Medical To the Within 2
To the comple 29b. Signature end title tiffier 29c. License number 29d. Date signed (Month, Day, Year) MA completed cause of deeth (Item 23a) (Type, Print) laran 1838 32. Registrer's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Death 3. Time of Deeth HENTSCHEL Month BERT september 16 11:45 AM 98 4b. City, Town, or Location of Death 4e. Fecility Nama (If not institution, give straat end number) 4c. County of Deeth Baltimore 5 Good Samaritian Hospital If Under 1 Year Months Days If Undar 24 Hrs. Hours Min. Birthplece (State or Foreign Country) 2/5/1919 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21206 Avenue 3809 Bayonne Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U.S. Armed Forces? 14. Race - American indlen, Bleck, White, etc. 1 Never Merried 2 Marriad 1 XYas 2 □ No if Yes, Giva Yeer or Dates: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Bendix Machinist 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Christine Rupp Paul J. Hentschell 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Paltimore Marvland 21206 19e. Informent's Name/Reletionship (Type, Print) 3809 Bayonne Avenue Baltimore, Maryland Hentschel Bertha L. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Dulance of Disposition (Neme of Dulance) Place of Baltimore, Maryland 20b. Placa of Disposition (Neme of 4 ☐ Donetion 5 ☐ Other (Specify) John C. Miller Funeral Home 6415 Belair Road Baltimore, Maryland 21206 23a. Pert1. Enter the disaasa, or control etions thet caused the shock, or heart feilure. List control cause on each line. etions thet caused tha death. Do not antar tha mode of dying, such es cardiac or respiratory errest, Approximete Interval Batween Onsat and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) nammia Due to (or es e consequença of) Cancer Due to (or es a consequance of): 23b. Dfd tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Ves 2 No 24b. Were eutopsy findings availabla prior to completion of causa of deeth? 24a. Wes an autopsy performed? 1 ☐ Yes 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

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Box 86760.

or Attending Physician: The law requires that the deal

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Division of Vital Records, P.O.

Physician/Medical Examiner

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7 is merked other than "natural", or items 23s or 28s-f sho traumatic event, "is Medical Examinar musit to nothlist as

permit. Pages 1 and 2 should be filed within 72 hours aftar death 1 Department of Haalth and Mantal Hygiena. Important: if item 27 is marked other than "natural", or items 22 any injury or other traumatic excess.

Baltimore, Maryland 21215-0020

Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last

Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical axaminer? 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 25 No 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred

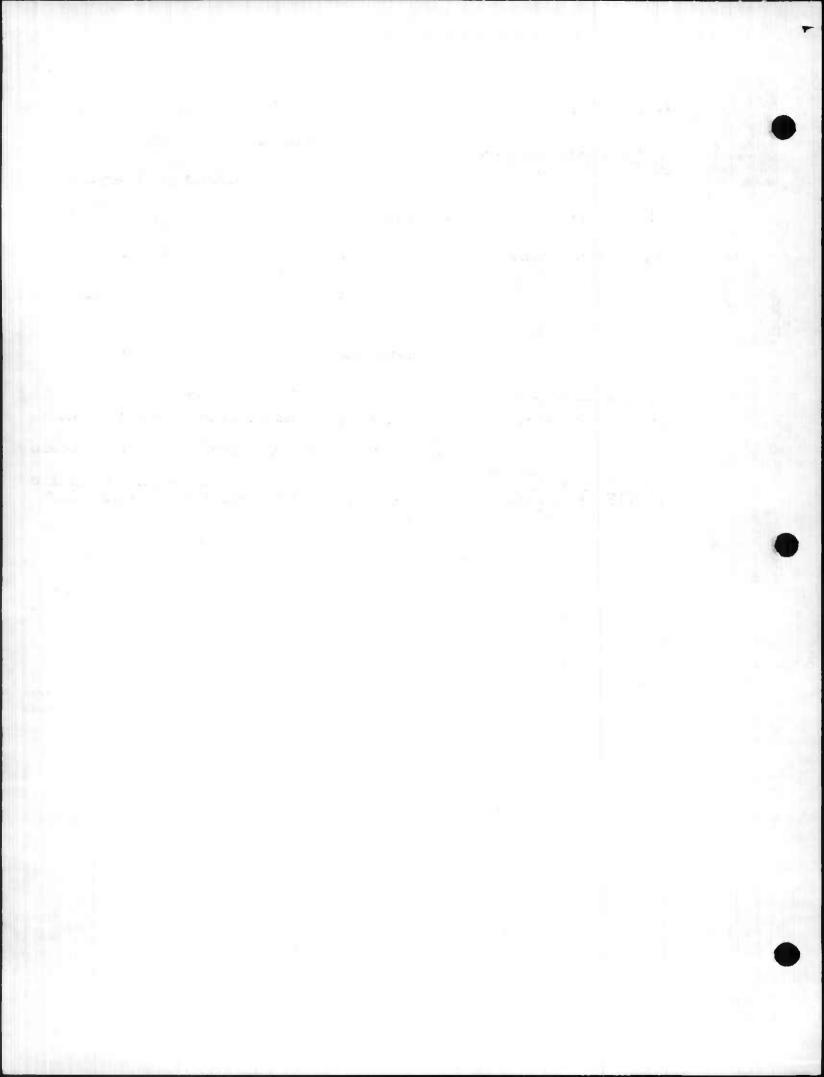
28a. Dete of injury (Month, Day Year) 28c. injury et Work? 1 Naturei 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29e. Certifier 112 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end manner stated.

Po 584 29d. Data signed (Month, Dey, Year) 29b. Signature end title of certifiar Youssef, september 16 1998

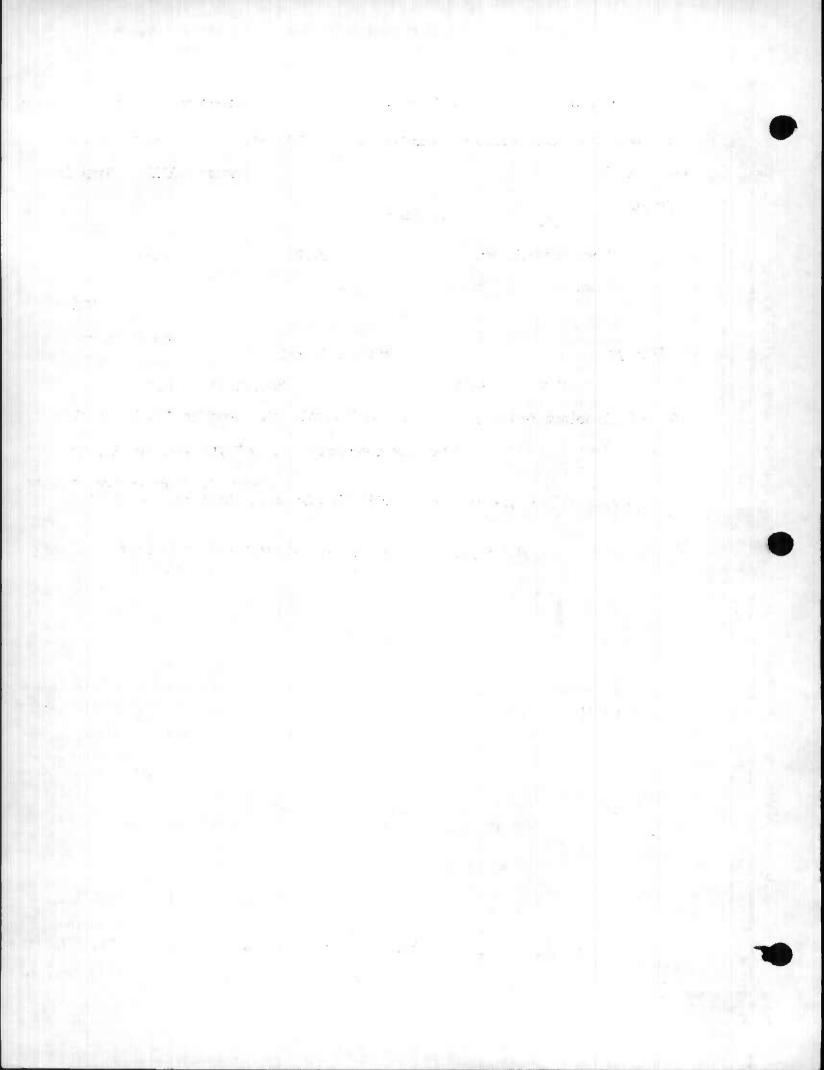
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) J. had Tousse f. MD; Good Samav. Tan Raven Boylevard, Baltimore MD 21239 HOSP. tal 5601 Loch

State Registrar 32. Registrer's Signeture Sparke



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H	Funeral Director	226-20-5311	. Sex 7. A	ge (In yrs. lest birth	Months Days	Hours Mi				place (Stete or Foreign otry)
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	23e or	246 West Ed	gevale Rd.		2	1225		U.S.		
_	or items	11. Marital Status 1 □ Never Married 3 Married	12. Was Deceden Armed Forces	?] No	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Orlgin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		k, White,	ean Indian, etc. White
0-0	72 hours natural', dical Ex	15. Decedent's	Education	16e. [Decedent's Usual Occup	pation	vorkina	16b. Kind of Bu		
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Maryland	end end	19e. Informant's Name/Relationship			Mailing Address (Street 46 W. Edges					
	of Health Item 27 other tr	Jesse C. Inabine	t (spouse)		Disposition (Name of	vale ru.	Dete	20c. Location -		
Baltimore,	permit. Pages Department of I Important: If Ite eny Injury or of page.	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		Glen Ha	crematory or other pla ven Memori	al Pk.	9/20/98			The state of the s
	Physician /Medical Examiner	23s Part: Enter the disease, or canock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)			USROTIC	ing, such es card	liac or respiratory	errest,	R	Approximate intervel Between Onset and Death
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sion o	After fune	27. Manner of Deeth 1 Natural 5 Pending 2 Accident Investiga			ury Wo	ork?]Yes 2∐No	28d. Describe	how injury occur	red	Company of
Divis	of or Att	3 Suicide 6 Could no 4 Homicide determin	200. Placa of I	njury - At home, fari etc. <i>(Specify)</i>	n, street, factory, office			(Street and Numb own, State)	er or Rui	el Route Number,
	To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affert completely filled in by the funeral Medical Certification:	29a. Certifier 1 Cartifying (Check only one)	Physician: To the bes aminar: On the basis end menner:	of examination and	deeth occurred et the t for Investigation, in my	ime, date and pla opinion, deeth o	aca, and due to the courred at the time	e cause(s) end ma e, date and placa,	anner as a	stated. to the cause(s)
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Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥄 🦯 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Daath 3. Tima of Death r 23 1998 Month **Physician** September 10:53 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme If not institution, give street end number) Examiner Baltimore Sinai Hospital 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9 Birthplece (Stete or Foreign **Funeral** Months Deys Hours Min 1□M 2□F Yrs. **Director** Douth Usual Residence of Decedent the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Medical Exameres must be notified at ↑ Yas 2 No laryland ore Direct 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with WOOD Funeral death 12. Was Decedant Evar in U,S. Armed Forces? Was Dacedent of Hispenic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14 Race - American Indian 11. Merital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Dates: 1 ☐ Navar Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify by 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working jife. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementary/Secondery (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) should be and Mental Lo 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) Health of Hem 27 is 20b. Piece of Disposition (Name of 20c. Location - City or Town, Steta 20e. Method of Disposition Dete Pages 1 permit. Pages Department of Important: If it any injury or o 1 Ø Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Serviće Licensee 22. Nama end Address of Facility 5 22 orth Approximete Interval Between Onset end Deeth 23a. Part1. Enter the diseasa, or complications that caused the daath. Do not entar tha moda of dying, such as cardiac or raspiretory errest, shock, or hear failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pneumonia two weeks Examiner Due to (or es e consequence of): Examiner Non-oliguric Acute Tubular Necrosis one week Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or es a consequence of) Due to (or es e consequence of) Box **Physician/M** 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. The lew requires that tha 1 Yes 2 No 3 Probably 4 Unknown 2 ģ 24b. Were autopsy findings evellable prior to 24a. Was en eutopsy performed? Completed completion of cause of death? hes 1 Yes 2 No 2 NNO cartificeta Physician: 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 10 After this funeral 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of Certification: 27. Manner of Deeth 28c. Injury et Work? or Attending s after deau. 1 De Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide filled in by 4 Homicide 24 hours 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier edical

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31. Dete filed (Month, Day, Year) State Registrar

(Check only one)

29b. Signature end title of cartifier

30. Name and edfines of person who completed cause of deeth (Item 23a) (Type, Print) 2401 W. Belvedere Avenue, Baltimore, MD 21215 Girish V. Nair, MD

32. Registrer's Signeture SEP 2 4 1998

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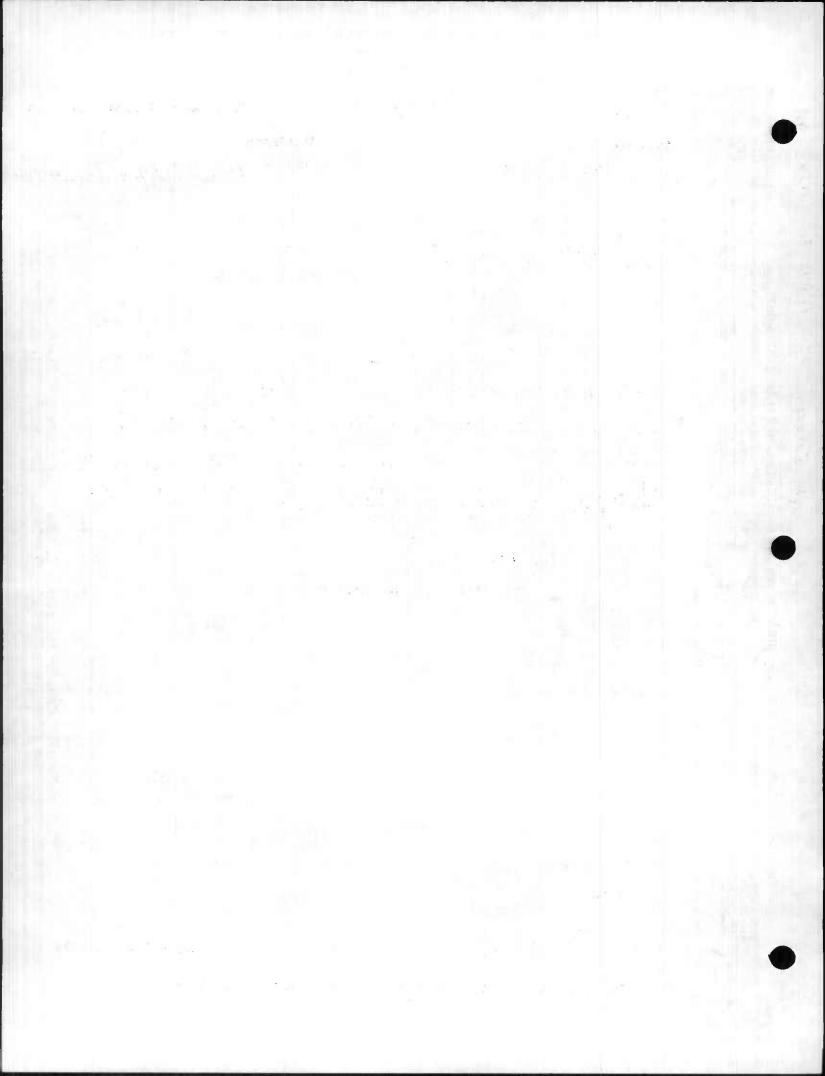
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29c. Licensa number

29d. Date signed (Month, Dey, Year)

September 23, 1998



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ackson **Physician** September 21 00 Vanc /Medical 4b. City, Town, or Location of Deeth 4c. County of Death give street and number) 4a Facility Name (If not institution, Examiner 9 If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs, last birthday) 9./Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Min. 10 M 200 Yrs Director Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Depertment of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, the BRGS. 18. Mother's Neme (First, Middle, Maiden Sumame) Be 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) (Husband 20b. Place of Disposition (Name of cemetery) crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22, Name and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock to heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, edical Due to (or es a consequence of) resulting in deeth) Last Physician Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contributa to the cause of death? The law requires that the 3 Probably 1 Yes 2 No Unknown by 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? certificete has or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death 1 Naturei 2 Accident 28d. Describe how injury occurred Certification: 28c. Injury at Work? After t 5 Pending investigation 1 ☐ Yes 2 ☐ No eral Director: A deeth. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) efter 4 \ Homicide To the Hospital within 24 hours 12 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and menner es stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year)

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State Registrar

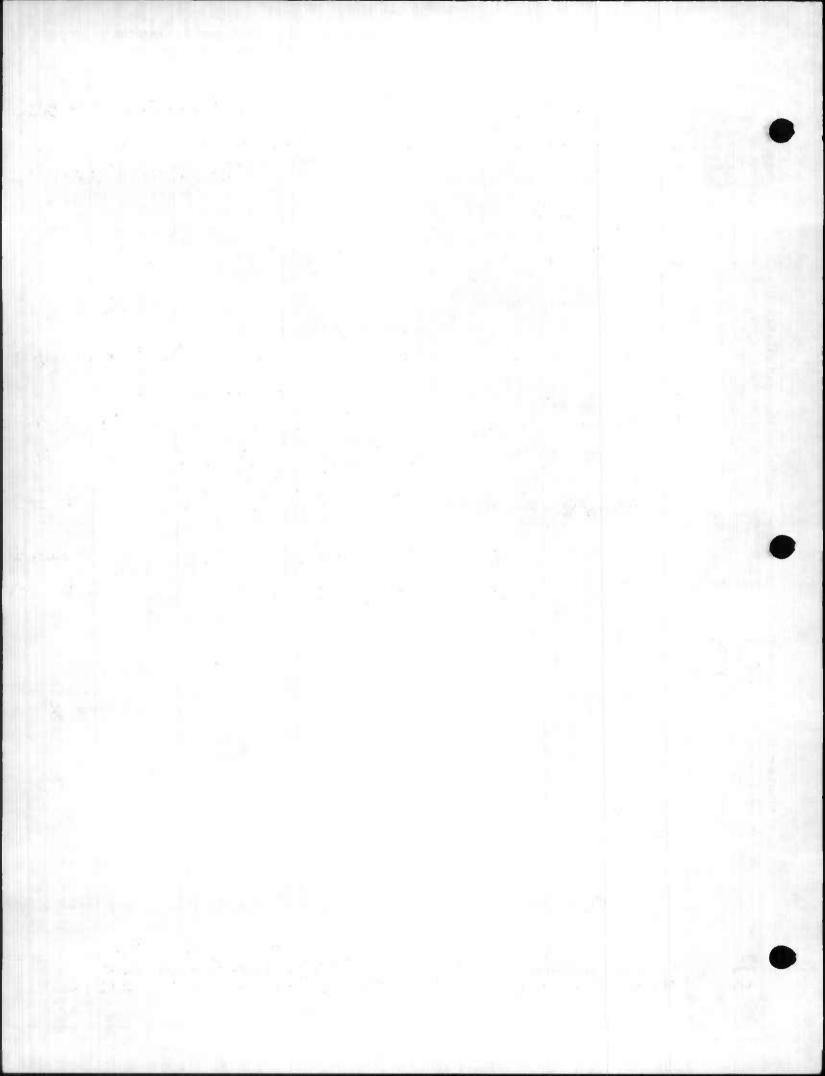
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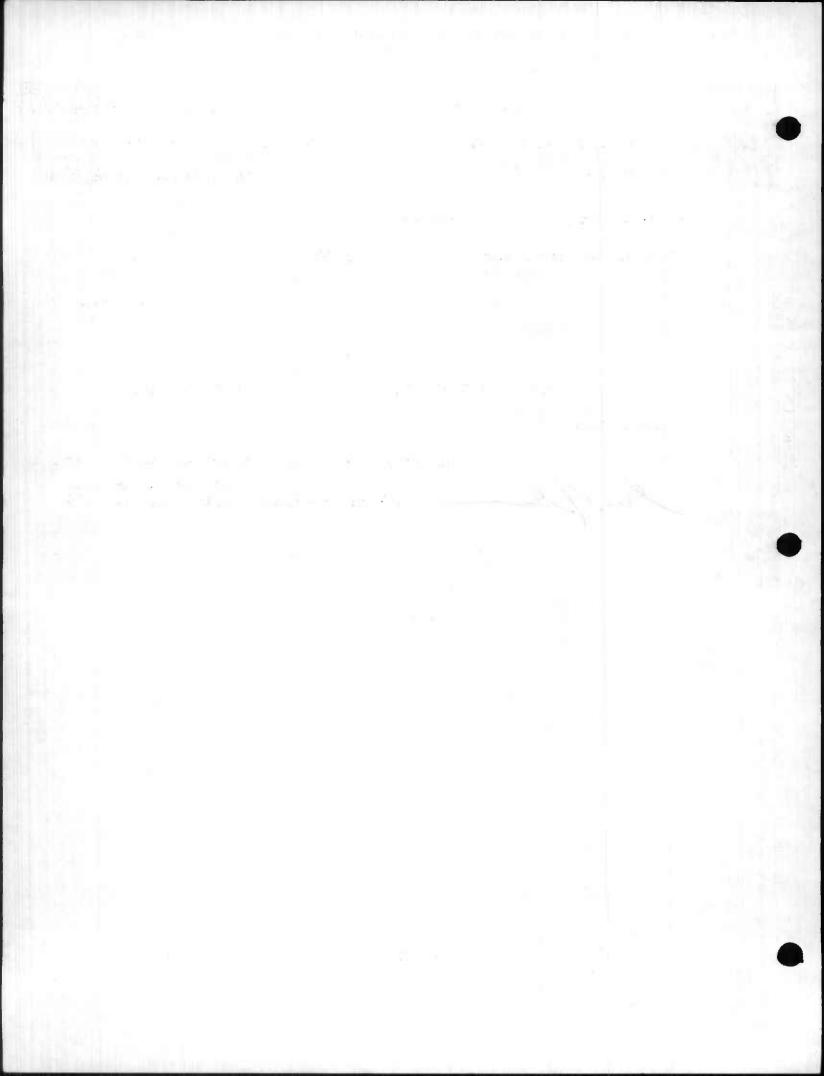
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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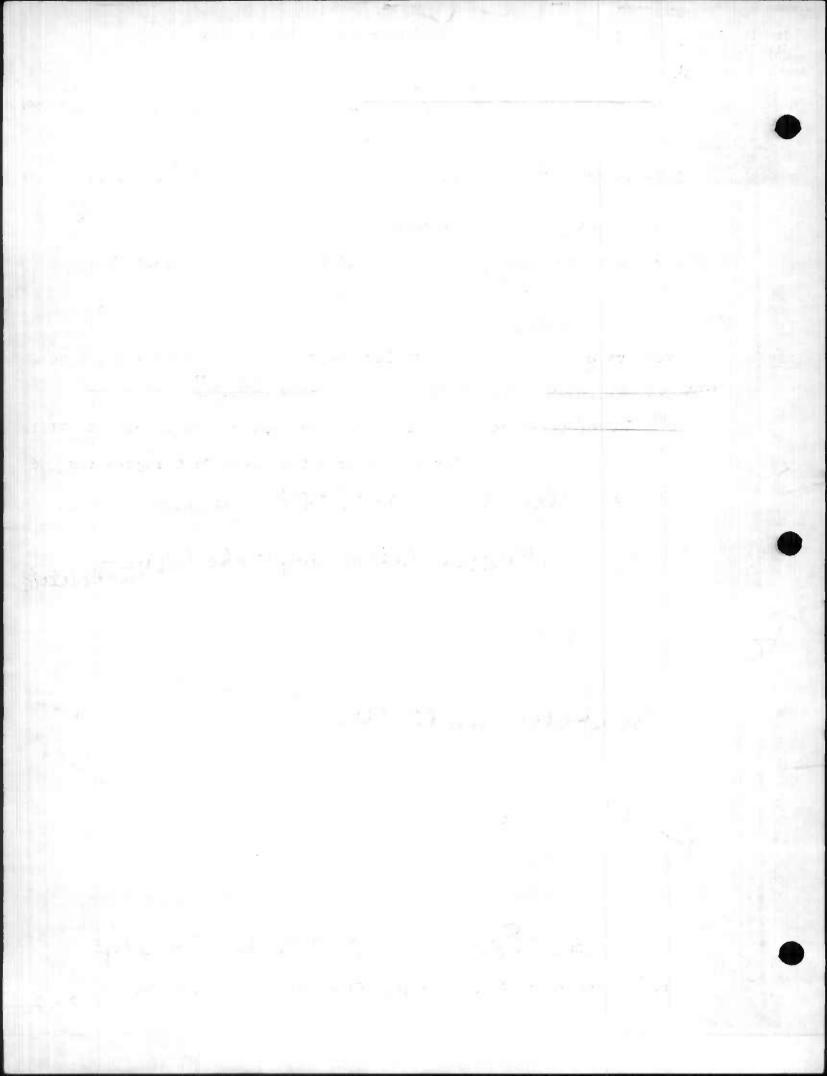
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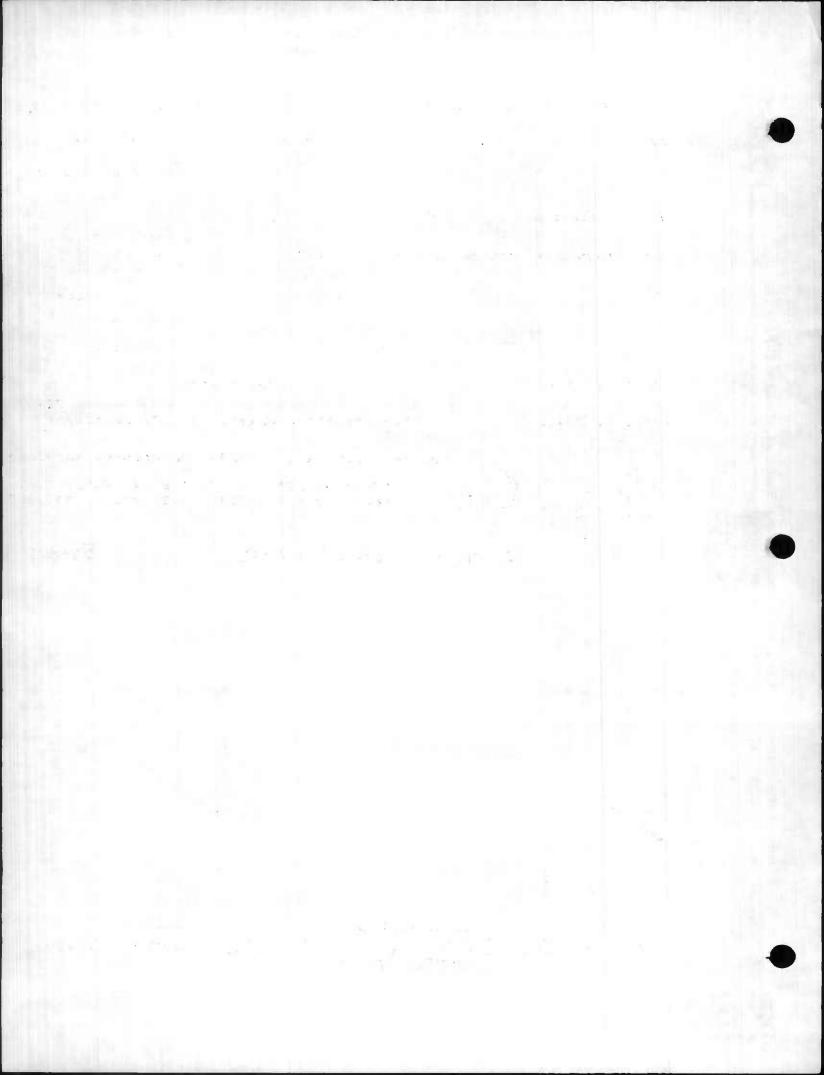


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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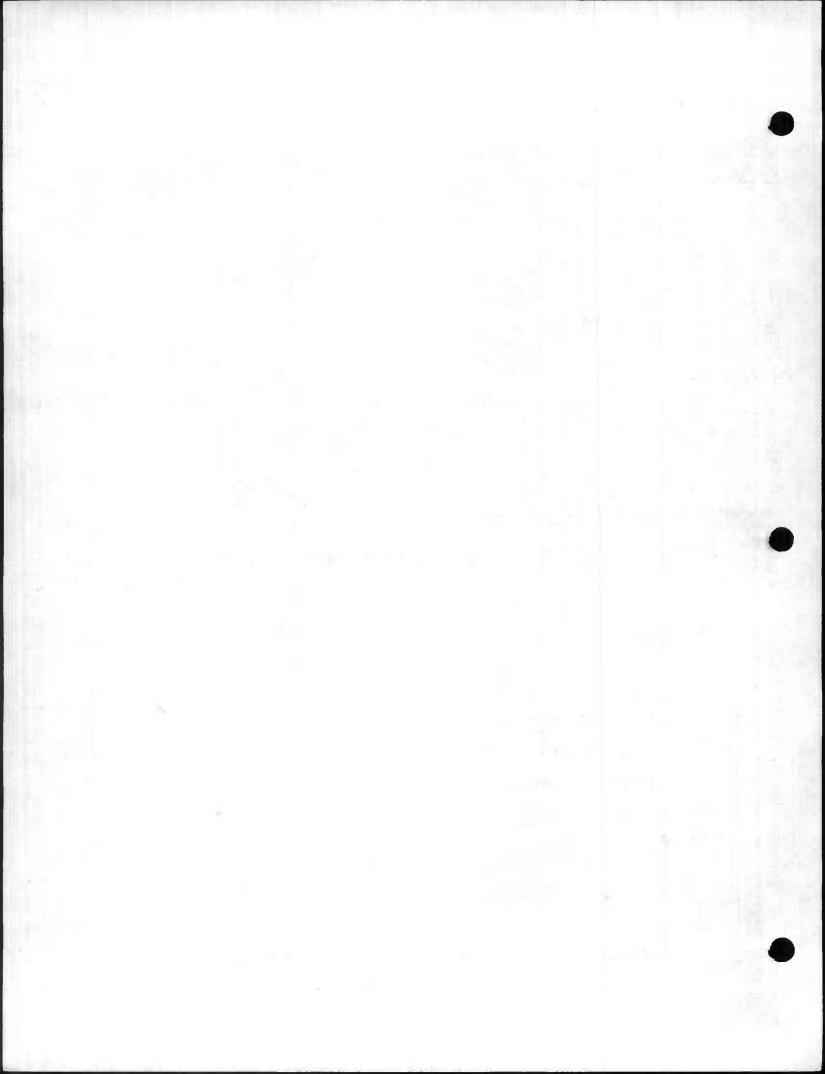
			Ce	runcate of	Deam		Reg. No.	
	1. Decedent's Name (First, Middle, L	ast)	NELECTION			2. Date of De Month	ath Day	3. Time of Death
Physician	RODRIQUE	MORVEN J	ONES					3,1998 7:30pm
/Medical Examiner	4a Facility Name (If not institution, g	ive street end number)			4b. City, Town, or			
LAdiminei	6723 Townbroo	k Drive,	Apt. B		Woodma	oor	Bal	ltimore
Funeral	5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Yea			th .	9. Birthplace (State or Foreign
irector	580-23-0207	1 € M 2 □ F	2.2 Yrs.	Months Days	s Hours Mir	10/4/	1975 F	Country) Trench Quarte
	Usual Residence of Decedent							
dail 10	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
notified at	MD Balti	more	Woodm	oor				1 ☐ Yes 2√ No
re per	10e. Street and Number			10f. Zip Code	The state of the s		10g. Citizen of V	Vhat Country?
10	6723 Townbro	ook Drive	Apt. B	21	207	0.00	$U \cdot S$. A .
for must be notified.	11, Marital Status	12. Was Decedent 8		Was Decedent of	Hispanic Origin? (ban, Mexicen, Pue	Specify Yes or No	- 14. Rac	e - Americen Indian,
Fur	1 Never Married 2 Married	Armed Forces?	lo			rto Rican, etc.)		k, White, etc.
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yes 2☑ No	Specify:		Specify	Black
8	15. Decedent's	Education	16a. Dece	dant's Usuel Occi	upation		16b. Kind of Bu	usiness/Industry
Completed	(Specify only highest g	rade complated)	life.	kind of work don DO NOT use retir	e during most of wo	orking		
Eo	10th	Collega (1-4or 5	Un.	known			Unk	nown
	17. Father's Name (First, Middle, La.	st)			18. Mother's Ne	eme (First, Middle	, Maiden Sumem	e)
To Be	Carlisle Joi	nes			Norm	a WESCO	ott	
) -	19e. Informant's Name/Relationship	(Type, Print)	19b. Malli	no Addrass (Stre	et and Number or F	Rural Route Numb	er. City or Town.	State, Zip Code) 21207
To	Norma B. Jone						1	Balto., MD
	20a. Method of Disposition		20b. Place of Dispo	osition (Neme of		Date		City or Town, State
	1 ☑ Burial 2 ☐ Cremation 3			metory or other p	tery 9/	25/00		ore, Marylan
	4 Donation 5 Other (Spec					23/30	Baltim	ore, margran
ouce.	21. Signature of Funeral Service Lic	gazee //	1 2	2. Neme end Add $LEROY \;\;\; O$	• DYETT	& SON	FUNERA	L HOME, P.A.
a	newy () Held	Annual Control					ALTO., MD2120
- 1	23a. Part - Erser the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do not en	tar the mode of d	ylng, such as cerdi	ac or respiratory a	rrast,	Approximata Interval Between
ian	U	U						Onset end Death
cal	Immediate Cause (Final diseese or condition	NASOF	HARYNG	FAL	CANCE	R		5 YEARS
ier	resulting in death)		Due to (or as a conse					
je 🚾				, , , , , , , , , , , , , , , , , , , ,				
Examiner	Sequentially list conditions	b	Due to (or as a consa	guence of):				
	if any, leading to immediate ceuse. Enter Underlying							
edicai	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events	C	Due to (or as e consec	uence of):				
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/ Physicla	Part II. Other eignificent conditions	contributing to death bu	it not resulting in the t	indenying ceusa (given in Part I.		_/	
Completed by Physicial							Yee 20 No	3 Probabty 4 Unknown
should be del						248 Was	s an autopsy	24b. Were autopsy findings
should leted						perf	ormed?	evailable prior to completion of cause
upidu							/	of death?
CO						10	Yes 2 No	1 ☐ Yes 2 ☐ No
Be	25. Was cese referred to medicel examiner?					eath (Check only	one)	
2	1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpatie	nt 3 DOA	Other: 4 \(\text{Nursing}	Home 5 Thes	Idence 6 Oth	er (Specify)
Ë	27. Manner of Deeth	28e. Dete of Injui (Month, Day	Year) 28b. Time of Injury	28c. in W	jury at	28d. Describe	how injury occur	red
atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat		, sany		Yas 2 No			
, E	3 Suicide 6 Could not determine	28e. Piece of inju	ry - At home, farm, st	reet, fectory, offic	0	28f. Location	(Street end Numb	per or Rural Route Number,
en	4 🗆 Homicida	building, etc	:. (Spacify)			Chy or re	iwii, Siala)	
<u>a</u>	29a. Cartifier 1 ☐ Certifying (Physician: To the best of	of my knowledga, daet	h occurred at the	time, date and place	ce, and dua to tha	causa(s) and ma	annar as stated.
edicai Certification:	(Check only 2 Medical Expone)	aminer: On the basis of and manner sta	examination and/or in	vastigation, in my	opinion, death oc	curred at tha tima	, data and place,	and dua to tha causa(s)
completely filled in by the funeral director, page Medical Certification: To Be Com	29b. Signature and title of certifier	men	cal on colony	E/10 W29c. Lice	nse number		29d. Date signe	d (Month, Dey, Year)
	\ an a el o	i in John	s Hopkins onc	olory (enter	D00 50	753		xr 22, 1998
	30. Name end address of person wh	Hall BOIL	more, LID	27587	20000		Jep ent.	. 0011778
	30. Name end address of person wh	o completed causa of de	eeth (Item 23e) (Type,	Print)				
	04 D 4-19 - 19 - 19		1.0					
State	31. Date filed (Month, Day, Year)	998 32. Reģistra	ar's Signature	Span	1/21			
legistrar	DEL NA	330	/-	Japon	2			



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 10:10 Am Linda Janice Sept 18, 1998 Johnson /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore 6809 Eastridge Road Baltimore Wunder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Director 219-54-2859 49 Feb 10, 1949 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 □ No Director 28a-f Baltimore Lochearn 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 must be Berne 23a 6809 Eastridge Road 21207 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces?

1 □ Yes _2 [X] No If Yes, Give Yeer or Detes: 11 Meritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bieck, White, etc. the Medical Examiner 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Teacher Baltimore City School permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If from 27 is marked other
any Injury or other traument other 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) unknown Be 2 Hazel Johnson 19e. Informant's Neme/Reletionship (Type, Print) mother 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Hazel Johnson 6118 Rich Avenue Catonsville, MD 21228 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Burial 2 Cremmon 3 Removal from Stete 5 Other (Specify) Woodlawn Cemetery Sept 24 Ballings 22. Name and Address of Facility NUtter Funeral Homes, Inc. 4 Donetion 21. Signeture of Funeral Service Licensee 2501 Gwynns Falls Pkwy Baltimore, MD 21216 unu 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervai Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) INFARCTION Myo carrial Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Preumonia. Division of Vital Records, þ 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes en autopsy performed? Completed HYPERTENSION 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hyper cHo LESTERO Lemia Attending Physician: 25. Wes case referred to medical axeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel
2 Accident 5 Pending death. 1 Tyes 2 No investigetion affer deat Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aff To the Funeral Di completely filled in 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner steted. 29e. Certifier edicai (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Como D 21328 30. Neme end address of person who completed cause of death (ftem 23a) (Type, Print) 4001 Liberty Heights Ave Balto. Ma 21207 JACOBS Cosmo 31. Dete filed (Month, Dey, Year) SEP 2 4 1998 32. Registrer's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 80 JOYCE SEPTEMBER 21, HENRIETTA - F. 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not Institution, give street and number) SLATER 4301 YERRY BALTIMORE HALL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 1 M 25 F 3 Yrs. 213-32-8413 YUN 12 1915 Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE PERRY HALL Mid 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SLATER AUE 21236 4301 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 12 NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) SEIBERT harles WILAMENA HALL 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PINEHILL DR BALTO MD 21162 5817 MRS Lois DeJULIIS 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State of FATH Cen 19/24/98 BALTO. MD 4 ☐ Donation 5 ☐ Other (Specify) C'ACTENS 22. Name and Address of Fecility HARTLEY MILLER 21. Signature of Funeral Service Licenses Funeral Home CHTD. eller Has Ford RD BALTO MA 21234 7597 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arrest cardiac Due to (or as a consequence of): ig years anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of) colon cancer Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending Investigation

Physician /Medical Examiner n and al-transit

permit. Peges 1 and 2 st Department of Heelth and important: If them 27 is m any injury or other traum pace.

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show trsumatic svent, the Medical Examinar must be nothled at

2 should be filled within 72 hours efter n end Mental Hygiene. is marked other than "natural", or ite

Saltimore, Maryland 21215-0020

the Marylend

page 2

the signed by t hes this funeral After death. efter deat Director:

Physician/Medical þ Completed Be To

Certification:

Medicai

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

Examiner

Division of Vital Records, P.O. 6 Hospital 6

To the F within 2

completely

Registrar

29b. Signature end title of cartifier Melisse Saull, an. D.

6 Could not be determined

D50360

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Sept. 22, 1998

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

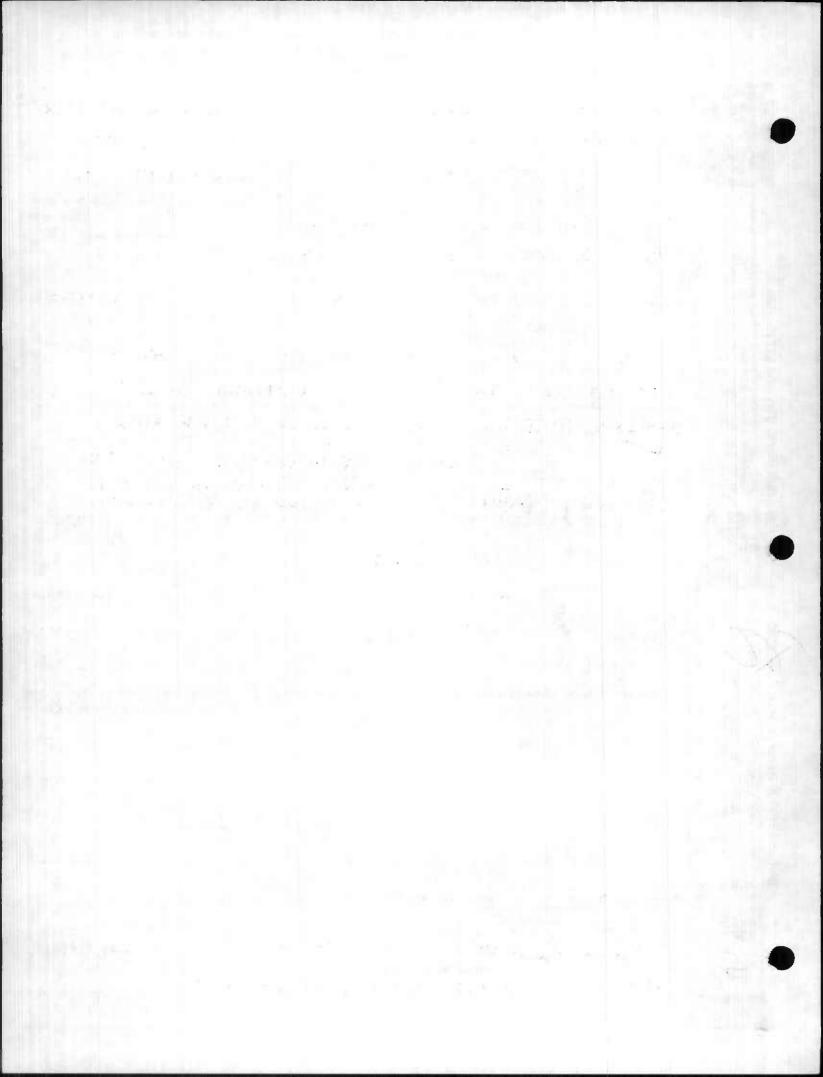
Baltimore mi 21222

29c. License number

1 Yes 2 No

Merritt Blvd. #17

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)



Funeral

Director

28a-f show

ð

flams 23s

'natural', or

Hygiene.

Pages 1 and 2 should be named of Health and Mental

Lepartment of Health an Important: If Item 27 is a sary injury or other traum 2058.

Physician

/Medical

Examiner

980

page 2

this funeral

hours after death.

6

filled in !

å

72 hours after

Baltimore, Maryland 21215-0020

Box 68760

P.0.

Division of Vital Records,

The law requires that the death certificate

or Attending Physician:

To the Hospital

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Theresa Kenon 8:08pm 21, 98 Sept /Medical 4a Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NA 1661 E. Coldspring Lane
5. Sociel Security Number 6. Sax 7. Aga (I 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Hours Months Days 1□ M 2 F 66 NC 224-40-2585 08-22-32 Usual Residence of Decedent 10a. Stete 10c. City. Town or Location 10b. County 10d. fnside City Limits MD NA Baltimore Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. #2nd Fl. 1661 E. Coldspring Lane 21218 Funeral USa 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yes & J.No If Yes, Give Yeer or Detas: Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Merried Specify: Black 1 Yes 28 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Faith Creative Elementery/Secondary (0-12) College (1-4or 5+) 3yrs School Teacher Learning Center 12th Grade 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Franklin Felton Viney Vann 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Earl Kenon+Crystal Felton 1661 E. Coldspring Lane Baltimore, Md. 21218 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State Woodlawn Cemetery 09-24-98 4 □ Donetion 5 □ Other (Specify) Woodlawn, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue ra 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause an each line. Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) O DAYS INFARCTION MYOCARDIAL Due to (or es e consequence of): SAME DAY Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evenis resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown þ 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Deeth 28a. Dete of fnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicida 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide with the pest of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and mannar as stated.

Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. edical (Check only

within 24 hours a To the Funeral C completely filled

State Registrar

EMIL DR 31. Date filed (Month, Dey, Year) 24 SFP

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAYEIL 201 32. Registrer's Signeture

UNTUESITY PARKWAY, BALTIMORE, MARYLAND EAST

29c. License number

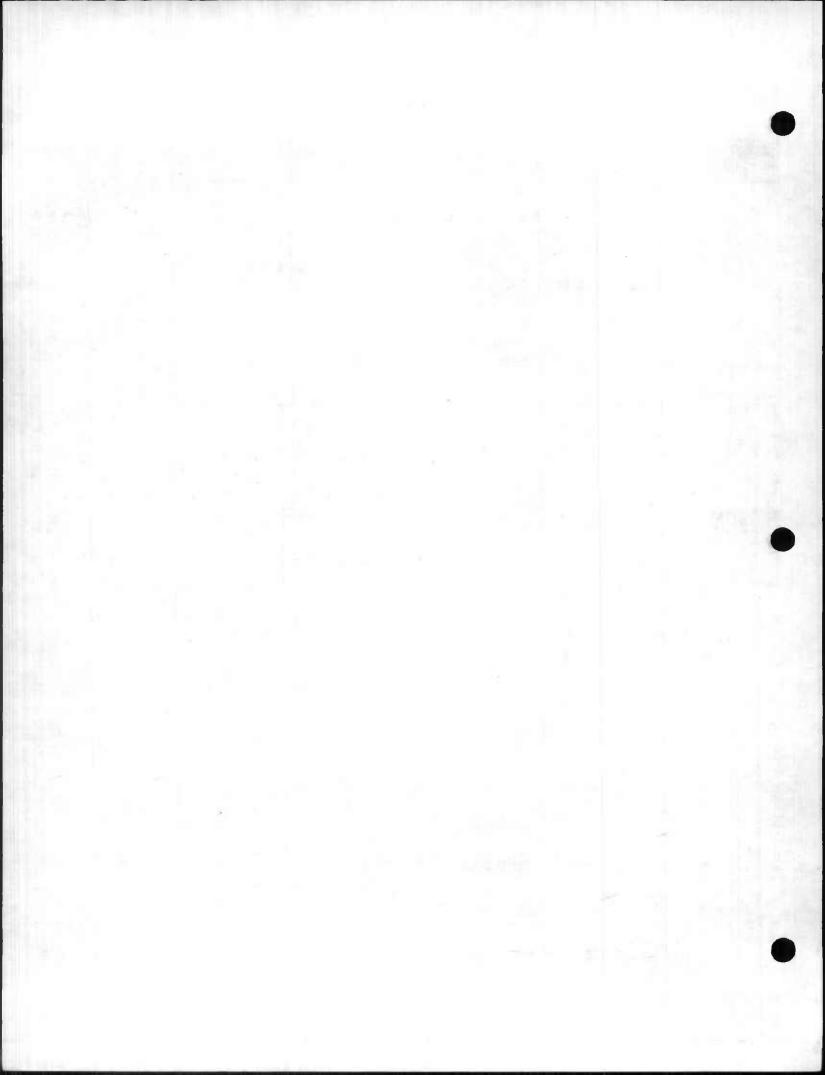
D0053183

29d. Date signed (Month, Day, Year)

22

1998

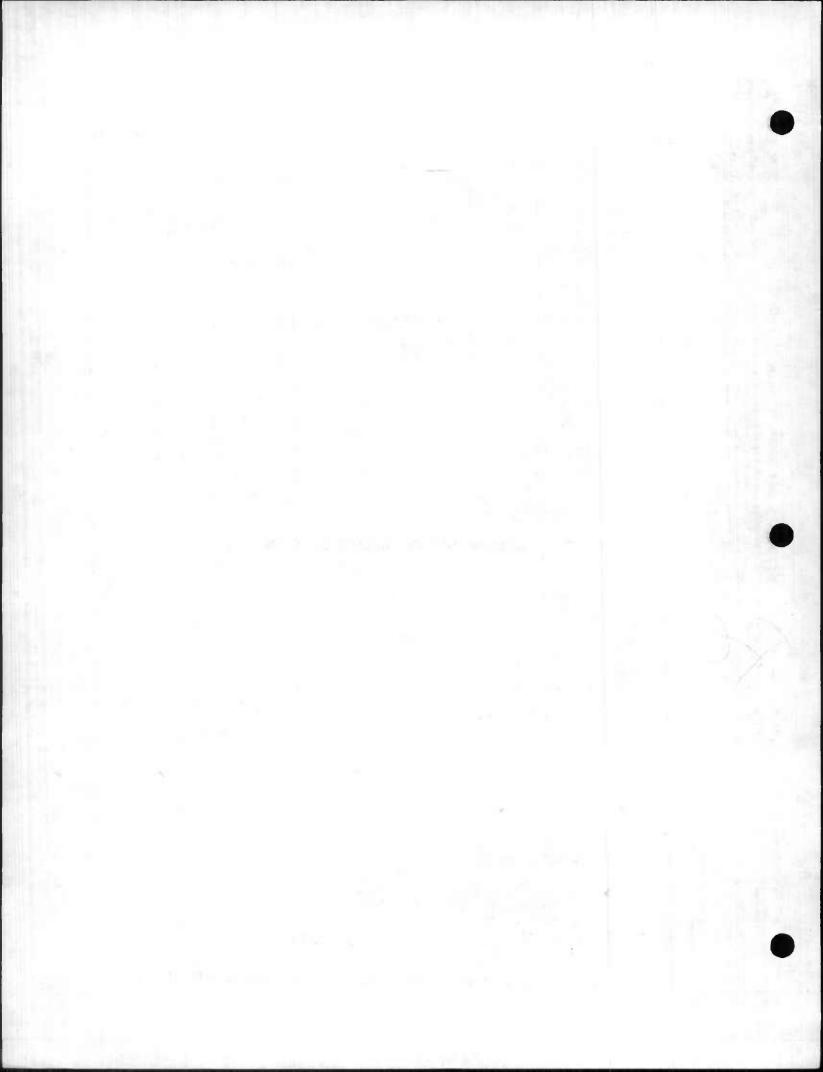
SEPTEMBER



State of Maryland / Department of Health and Mental Hygiene Amend: #8 Per FH Film G763 9-24-98RC Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Day Month **Physician** SEPTEMBER 21, 1998 8:00 P.M LAW ELSIE /Medical 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Saint Joseph Medical Center 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. 5. Social Sacurity Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days Hours 86 85yrs. 219-22-2038 Director May 24,1913 Maryland Usual Residence of Decedent 10a. Slete 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show than "natural", or flama 23a or 28a-f ahov the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Parkville Director Maryland 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 21234 9429 Ridgely 234 U.S.A. Funeral Herra 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whita, etc. 11. Maritel Stetus hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Nevar Married 2 Married natural', or 1 Tes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) Black & Decker ssembler 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) parmit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Nem 27 is marked other year property of other traumatic avant RORS. Be Edith R. Reese Samuel B. Law 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baldwin, MD 21013 2427 Baldwin Mill Rd. Jean T. Chenworth 20b. Place of Disposition (Name of cemetery, crametory or other place) Date PS. 24 20c. Location - City or Town, Steta 20a. Method of Disposition Buriel 2 Cremetion 3 Removal from Stala Jacksonville, MD hestnut Grove 4 □ Donation 5 □ Other (Specify) 1998 21. Signetura of Furreral Sarvice Licensee 22. Neme end Addrass of Fecility 1 chapel Evans FUNER 8800 Harford Rd Baltimore, MD 21234 23a. Part f. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** SEVERE MITRAL REGURGITATION /Medical Immediate Cause (Finel disease or condition resulting in deeth) **Examiner** Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): Box Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? Records, P.O. ĕ 1 Yes 2 No 3 Probably 4 Unknown RESPIRATORY FAILURE þ 24b. Were eutopsy findings aveilable prior to Completed 24a. Was an eutopsy performed? RENAL FAILURE completion of ceuse of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital 8 25. Wes case referred to medicel examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 TYes 20 No 를 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Attending 5 Pending 1 Naturel death. 1 TYes 2 No Investigation 2 Accident i or Attend after deat Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide n 24 hou. Funeral Dir Hospital 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner steted. (Check only one) Within 2 To the 9 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif D 24034 30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print) 7620 YORK ROAD TOWSON, MARYLAND 21204 TIMOTHY LOW, M.D., 31. Dela filed (Month, Day, Year) SEP 2 4 1998 32 Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar



city Yes or No-Rican, etc.) og 1 (First, Middle, M. Hall I Route Number, t Balt Date 2	Dey Ye R 22, 19 4c. County of I Ba Year) 1909 Og. Citizen of Wha United 14. Race Black, V Specify: 16b. Kind of Busin OWN faiden Surname) City or Town, Statimore, N 20c. Location - City	Death Itimore Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
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1 00 50 Michael E. Callapp Loopand 7 Buck Inc. 5305 Harrord Road									
Baltimore, MD 21214									
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line.									
Immediate Cause (Final CONGESTIVE HEART FAILURE disease or condition									
resulting in death) Due to (or es e consequence ot):									
ISCHEMIC CARDIOMYOPATHY									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
Cause (Disease or injury that initiated events Due to (or es a consequence of):									
d									
23b. Did to	bacco use contri	bute to the cause of death?							
	Yes 2□ No 3□ Probably 4 Nunknow								
24a. Was ar perform	24b. Were autopsy tindings available prior to completion of cause								
		of death?							
1 ☐ Ye	s 2N No	1 ☐ Yes 2 ☑ No							
(Check only one									
examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 1 Natural 5 Pending (Month, Day Year) Natural 5 Pending Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of light Work?									
8d. Describe ho									
28d. Describe ho	reet and Number	or Rural Route Number,							
28f. Location (Str	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Inc.) City or Town, State)								
28f. Location (Str									
28f. Location (Str City or Town	use(s) and mann								
28f. Location (Str City or Town		er as stated. I due to the cause(s)							
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7	ome 5 Reside 28d. Describe ho 28f. Location (St.	me 5 Residence 6 Other 28d. Describe how injury occurred 28f. Location (Street and Number							

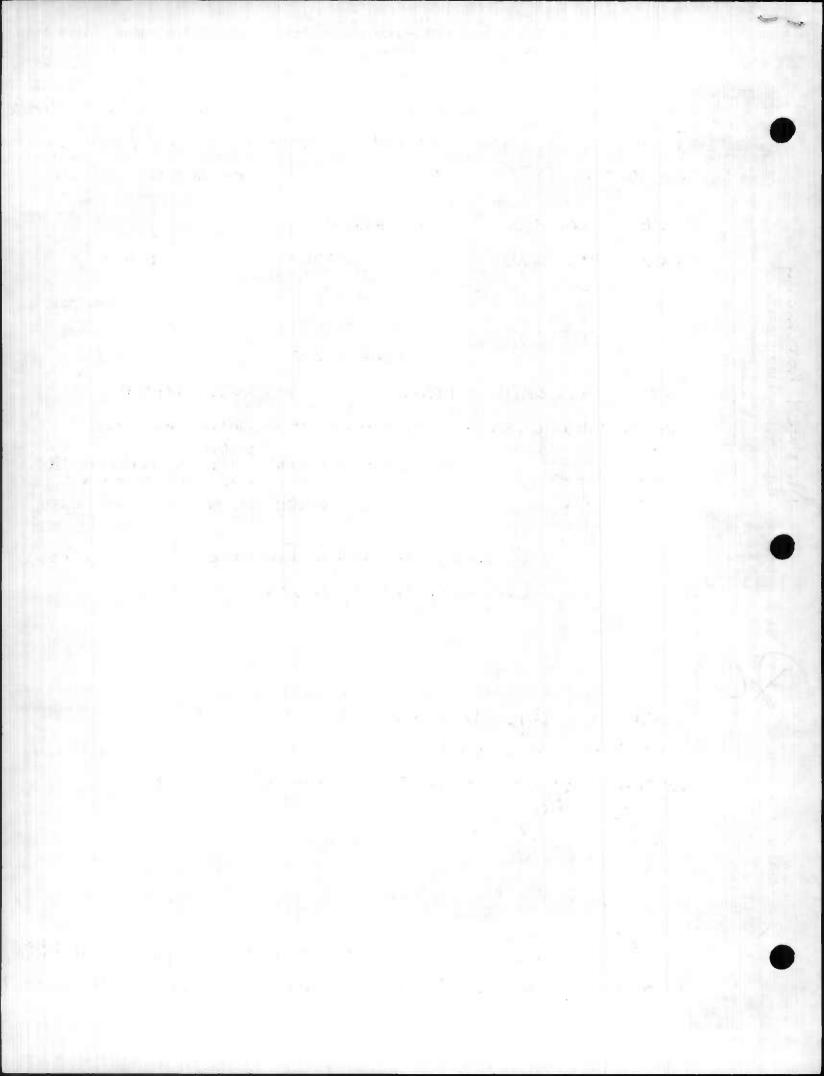
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Physician** 7:59AM ROSEMARY MAXWELL /Medical 4e Fecility Name (If not institution, give street end number) Examiner Rosedale Franklin Square Hospital Baltimore Center If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 10M 20 F Months Days Yrs 038-18-7713 Usual Residence of Decedent Director the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Director MD BALTIMORE MARSH WHITE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the Health and Mental Hybjane. The marked other than "natural; or items 33a or in the marked other than "natural; or items 53a or in the traumatic avent, its would SIA 10024 CRANE ANE 21220 Funeral iaxwell, Rosemany 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondery (0-12) Cotlege (1-4or 5+) AT HOME HOME MAKER 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be GERTRUDE WARD ETLSWORTH BROWN HAPPER 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnforment's Name/Relationship (Type, Pnnt) Peges 1 end 2 nent of Health a ant: If item 27 is ury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE, MO. 21220 JAMES MAXWELL , SPOUSE 20e. Method of Disposition 20c. Location - City or Town, State Dete SEPT. 14, Important: If it any injury or c 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILLS MEM. GDNS. 1998 WHITE MARSH, MD 21. Signifule of Funeral Service (Consec 22. Name end Address of Fecility EVANS CHAREL OF MEMORIES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21737 Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Years Examiner Examiner seasc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (of as a consequence of): 68760 Physician/Medical Due to (or as a consequence of): Box Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O es, Hypertension, Status 1 Yes 2□ No 3 Probably 4 ☐ Unknown þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Post Myocardial Infarction, Lung Carcinoma, Ventricular Arrhythmia 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 Yes 2 No Be 26. Place of Death (Check only one) To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Dete of tnjury (Month, Dey Year) 5 Pending Attanding 1 Naturat 2 Accident 1 Yes 2 No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) after Direc 4 Homicide to Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 25 To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who Herman 30. Name and address of person who con mpleted cause of death (Item 23a) (Type, Print) Franklin Square Drive Baltimore, Maryland 263 9000 Dr. Herman

Registrar

31. Date filed (Month, Day, Year)

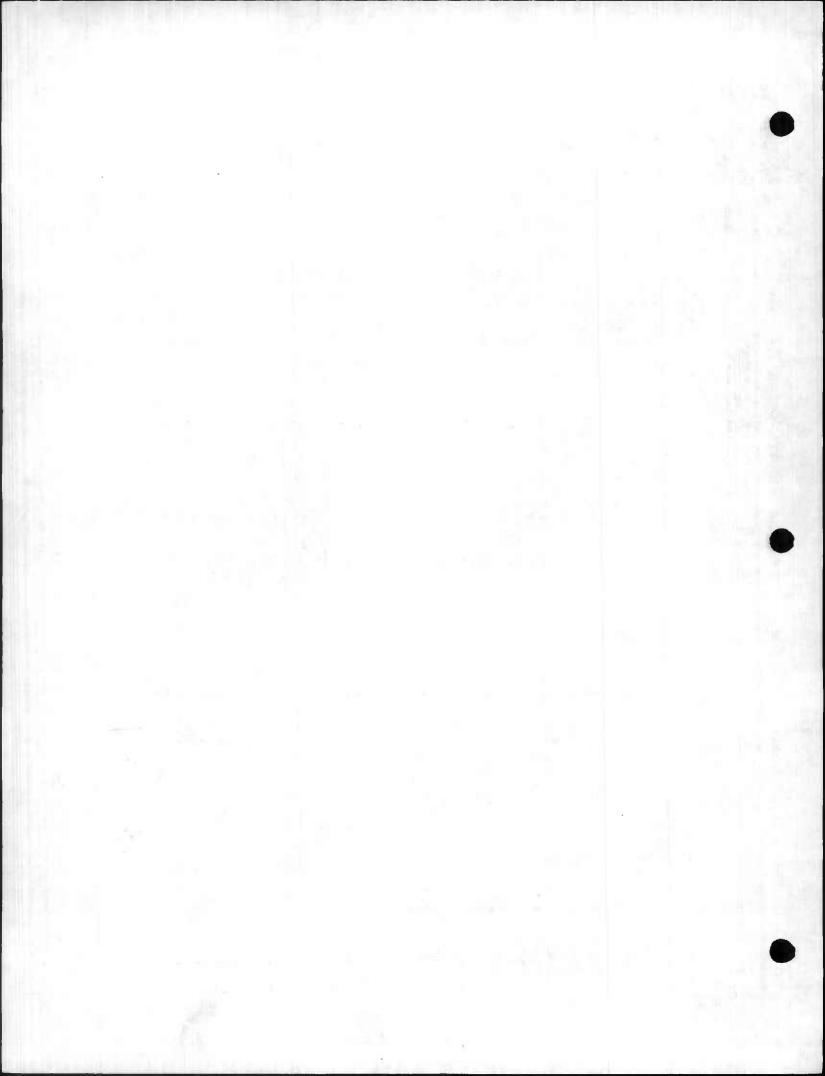
32. Registrar's Signature

SEP 2 4 1998

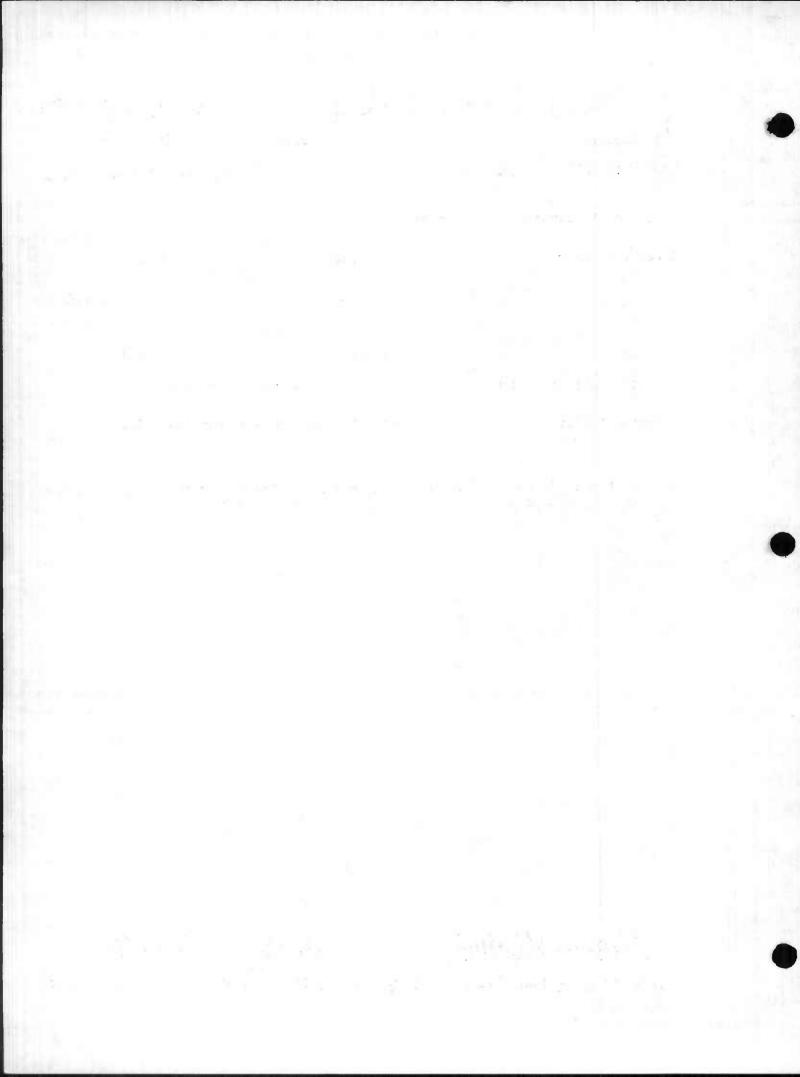


State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Re	eg. No.	6 29257							
Dhuninian	Decedent's Name (First, Middle, Last)	2. Data of Deat Month	h Dey Yea	3. Tima ol Death							
Physician /Medical	Jerry D. Miles Sr.	Sept.	21, 98	5:30pm							
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Tow	m, or Location of Death	4c. County of D	eath							
9 7	6805 Parsons Avenue Balti		NA								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs. 1. Age (In yrs. last birthday) Yrs. 1. Age (In yrs. last birthday) Yrs. 1. Age (In yrs. last birthday) Wonths Days Hours Usual Residence of Decedent	Min. 8. Data of Birth (Month, Day, 08-16	Year)	Birthplace (Stata or Foraign Country) MD							
Pun Man	10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits							
Mary to	MD NA Baltimore			1X Yas 2 No							
within 72 hours after deeth with the Maryland within "natural", or flame 23s or 28s-f show the Medical Examiner must be notified at empleted by Funeral Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What	Country?							
	6805 Parsons Avenue 21207		USA								
	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Original It Yas, specify Cuban, Mexican,	in? (Specify Yas or No-		marican Indian, /hita, atc.							
at a de la la la la la la la la la la la la la	1 Never Married 2 Married 1 Yas 2 No	T donto Friodri, dio.j	Specify:								
aral. o	3 □ Widowed 4 □ Divorced Year or Datas:		B.	lack							
be flied within 72 ho tel Hygiena. d other then "natura event, the Medical Be Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most	of working	16b. Kind of Busine	ss/Industry							
The Paris	Elementary/Secondary (0-12) College (1-4or 5+) Iiia. DO NOT use retired)		Manuala								
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marked Imate	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number										
and 2 a polith or n 27 la or trau	Allison D. Miles 6805 Parson Aven										
-125	20a Method of Disposition 20b. Place of Disposition (Name of	T	20c. Location - City	_							
Pages nent of int: If Ik iny or o	nt Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cernatory or other place) Baltimore Cemetery	09-25-98	Ralti	more, Md.							
	22. Nama and Address of Facility			land 21202							
parmit. Depart import eny inj	NO - 10 0 0 0	Daitimol									
	WM.C.March FF 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.			Approximete							
Physician	shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death							
/Medical	Immediate Cause (Final	Vania									
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Wronic Myeloid Leukenia years Due to (or as a consequence of):										
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and and darkmansit	Sequentially list conditions Dua to (or as a consequence of):										
N N	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):										
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The law require sate has been all page 2 should Completed		24a. Was a perform		b. Ware autopsy lindings available prior to complation of cause							
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tal or Attending Physics a star death. I Director: After this of ind by the funeral director. Certification: To	4 Homicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)	28I. Location (St City or Town		r Rural Routa Number,							
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To the Hospital or within 24 hours after To the Funeral Dire completely filled in b Medical Certi	29a. Certifier (Check only ane) Check only ane) Check only ane) Check only and Examiner: On the best of my knowledge, death occurred at the tima, data and and aner stated. Check only and manner stated.	h occurred at the time, do	ata and place, and	due to the cause(s)							
Me the	29b. Signature and title of certifier. 29c. License number	2	9d. Data signed (M	onth, Day, Year)							
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11	Mysty Claud Sce/MD D5032	2 3	replembe	469170							
7	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D 21287									
Ctoto	31. Data filed (Month, Day, Year) 32. Registrar's Signatura	21281									
State Registrar	SEP 2 4 1998 Jenera G. Sporks										
•	Mari a fragality										



State of Maryland / Department of Health and Mental Hygiene Amend: #24a Per MD Film G763 9-24-98RC Certificate of Death Reg. No 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 8:00 /Medical 4e. Facility Neme (If not institution, give streat and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Catapult Court Baltimore Essex 8. Date of Birth (Month, Day, Year) If Under 1 Yaer Months Days If Undar 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 200 Days 2420 79 Yrs 1918 West Virginia **Director** Usual Residence of Decedant 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits the Marvia r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Baltimore Essex 1 ☐ Yas 2 ☐ No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? with 1 Catapult Court 21220 U.S.A. Funeral death 12. Wes Decedant Evar in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Maritai Status Black, Whita, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Yes 2 No If Yes, Give Yaer or Datas: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: white p Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Teacher School School 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Gail Washington Riggs Louisa Duncan Shaffer 10 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) . Paul Oxley/son of Health 1 Catapult Court, Essex, Maryland 21220 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 Department of Important: If it any injury or o 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☑ Donation → □ Other (Specify) 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street 21. Signatura of Funeral Service License RODA I d Wade, Director Baltimore, Maryland 21201 Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Physician Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical Examiner Examiner **Durisi-tran** Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in daath) Last Due to (or as a consequence of) physician the burla Physician/Medical Due to (or as a consequence of): 10 997 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed certificate has 1 Yes 2√ No 1 ☐ Yes 2 ☐ No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Deeth Certification: 28e. Date of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending after death. 1 Yes 2 No Investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide ò 24 hours a Hospital 18 Certifying Physician: To the best of my knowladge, daeth occurred at tha time, dete end piece, end due to the cause(s) end manner es steted.
2 Medical Examiner: On the best of examinetion and/or invastigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end manner steted. 29e. Certifian Medicai completely (Check only one) within 2 \$ 29b. Signature and little of certif 29c. License number 29d. Data signed (Month, Day, Year) 0 30. Name and eddress of a cause of deeth (Item 23a) (Type, Print) Raltinute, US 21239 Loch Kaven Lurks 100 31. Dete filed (Month, Dey Yeer, 32. Registrer's Signetura State 2 4 1998 SEP Registrar books



98-5160-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. cm State of Maryland / Department of Health and Mental Hygiene William Perkins ITEMS: #23, 27, 28 PER MEO G763 9-28-98 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Villiam September 02, 1998
4b. City, Town, or Location of Death 4c. County of Death 1998 6:12 P.M. /Medical 4a Facility Name (If not Institution, give street and number) Examiner University of Maryland Hospital Baltimore If Under 24 Hrs. If Under Months Date of Birth Month, Day. 7. Age (In yrs. last birthday) 3 4 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 100 M 20 F 219-76-2969 Usual Residance of Decedant Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MYes 2□No Directo d saltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1430 W.
11. Marital Status 2/21' St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 Yes 2 No Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Blac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) unemp 0 yea 12 i. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If item 27 is marked other ti jury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be othia 0 William Pugh HORKINS POSKINS 19a. Informant's Name/Relationship (Type, Print)/MOTHET 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) Cynthia 1430 W. MO DerKIAS saltimore Md. 2/2/7 sher st altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetary, cramatory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Department important: If ansdowne, md Injury o 4100 4 □ Donation 5 □ Othar (Specify) 22 Name and Address of Facility Signature of Funeral Service Licensee Joseph L 2222w. north Que, Baltimore, Md ass 23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final COCAINE, ALCOHOL AND NARCOTIC INTOXICATION disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and physician Division of Vital Records, P.O. Box 68760 20 Physician/Medical 4 Due to (or as a consequence of) 뿚 990 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably yd bengis à 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed need page 2 768 10 Yes 2 No 2CI No certificate Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient ※☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 M Yes 2 No ã funeral 27. Manner of Death 28c. Injury at Work? 25d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: Attor 5 Pending investigation Hospitat or Attending 1 Natural UNKNOWN FOUND: 9-2-98 FOUND: 1 Yes 2 No 2 Accident aftar denti 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: DWELLING 28f. Location (Street and Number or Rural Route Number, City or Town, State) 720 BRUNE STREET 4 ☐ Homicide BALTIMORE, MARYLAND pelli 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the ceuse(s) and manner as stated.

Wedical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier edicai

State Registrar

THE MORE MIKIN 31. Date filed (Month, Day, Year) SEP 2 4 1998 32. Registrar's Signatura

30. Name and address of person who complated could of death (Item 23a) (Type, Print)

ny

29b. Signature and title of certifier

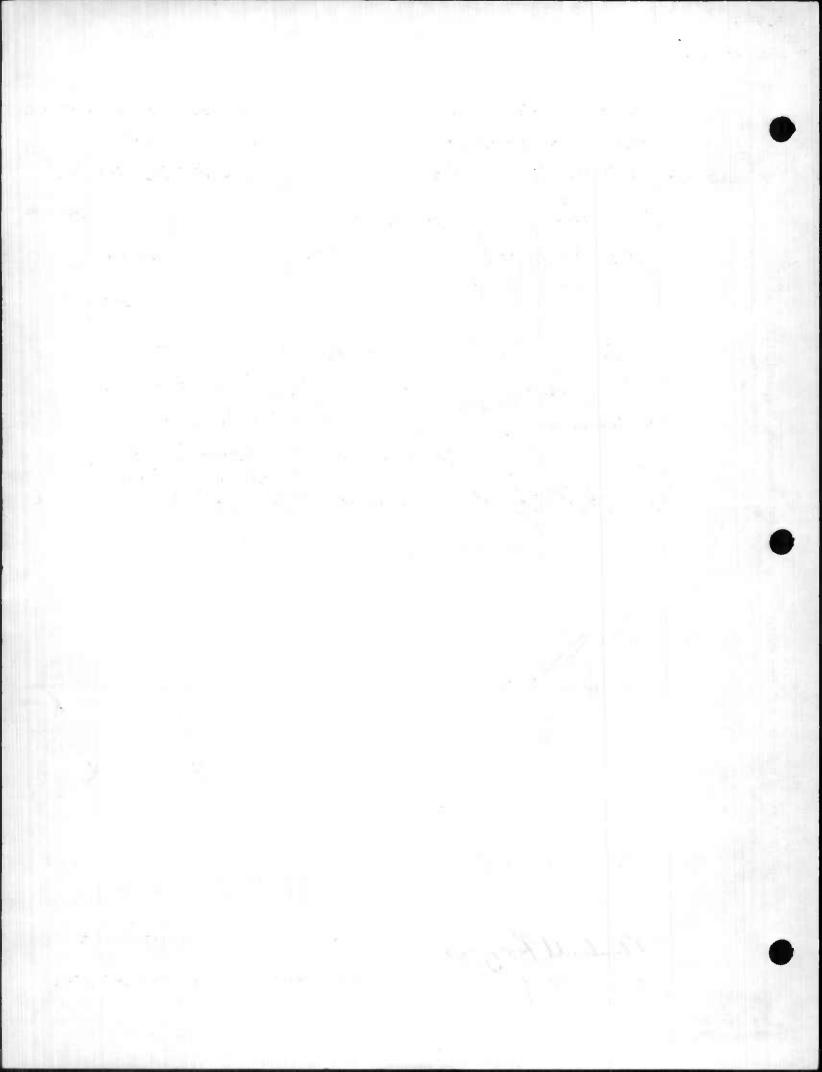
111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

September 03, 1998

29c. License number

O.C.M.E.



Please Type or Print in Biack indelibie ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month 30AM OMINI Joseph 0 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death Nactord Hospital 8. Date of Birth Month, Day 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 10-3938 Months Days &MYrs. 1 MM 2□ F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 DENo 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc., 11 Merital Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Maryland 21009 20b. Place of Disposition (Name of cemetary, cremetory or other place) Sept. 4 20a. Method of Disposition 20c. Location - City of Town, State 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Valley Men. 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenses Evans Function 8800 Harror Haltord Rd 23a. Pert1. Enter the disease, or complications that cause. The death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each tine. Approximata Intervel Batween Onsat and Death Immediate Causa (Final Zum diseasa or condition resulting in death) Vo me to Sequentially fist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yaa 2 | No 24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of daeth? 200 No 1 Yes 2 No 1 ☐ Yes 25. Wes case referred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 15 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of fnjury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760 Physician/Medical Division of Vital Records, à Completed Be Certification: To 事 After Attending To the Hospin within 24 hours after death.
To the Funeral Director: A death.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at

72 hours after

illed within 7 Hygiene.

permit. Pages 1 and 2 should be filed wit Dependent or Health and Mental Hyglens Important: if item 27 is marked other than eny injury or other treumatic event, the banca.

Physician /Medical

Examiner

Baitimore, Maryland 21215-0020

Director

Funeral

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Completed

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State Registrar

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29e. Cartifier (Check only one)

RENE

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

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SANTOS

32. Registrer's Signature

30. Name and address opperson who completed cause of death (Item 23a) (Type, Print)

109

SEP 2 4 1998

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

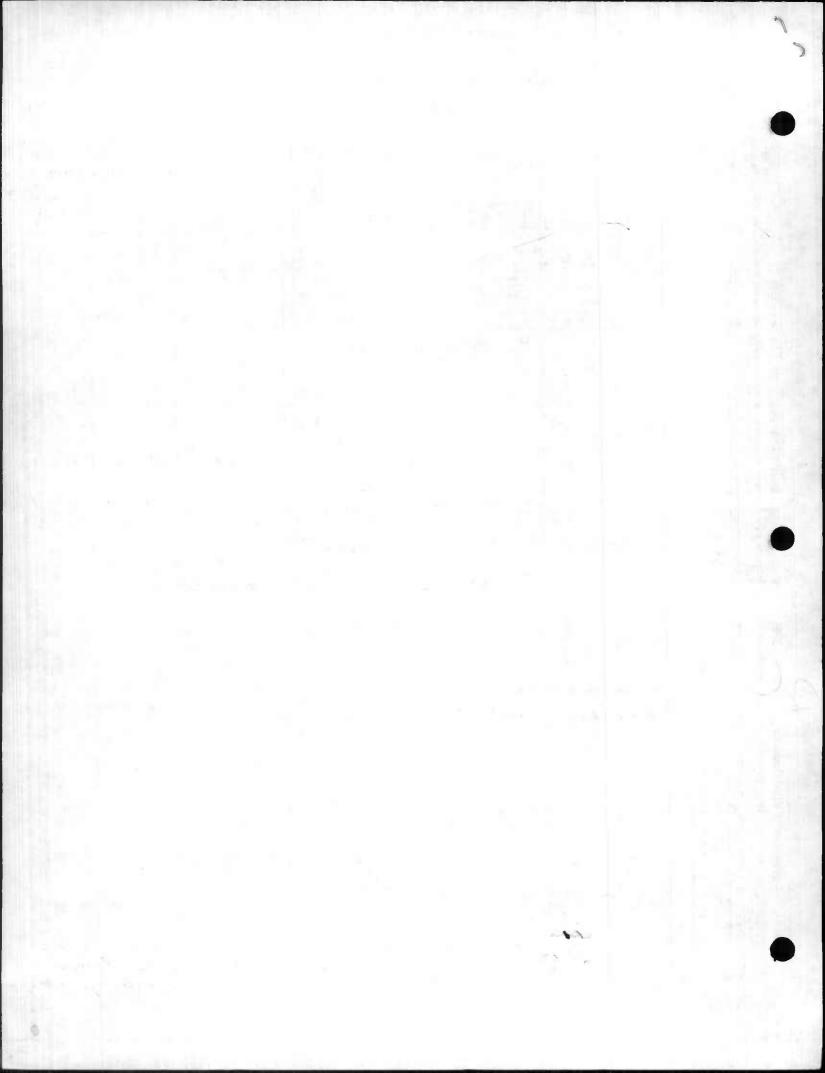
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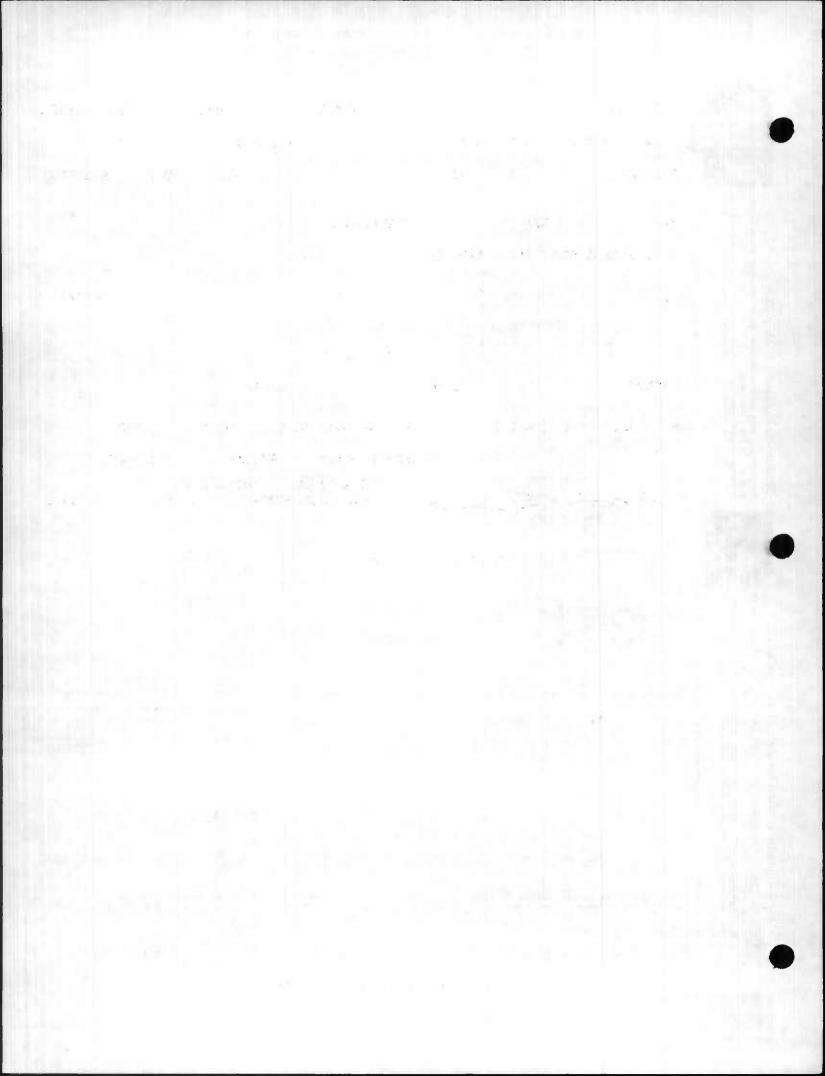
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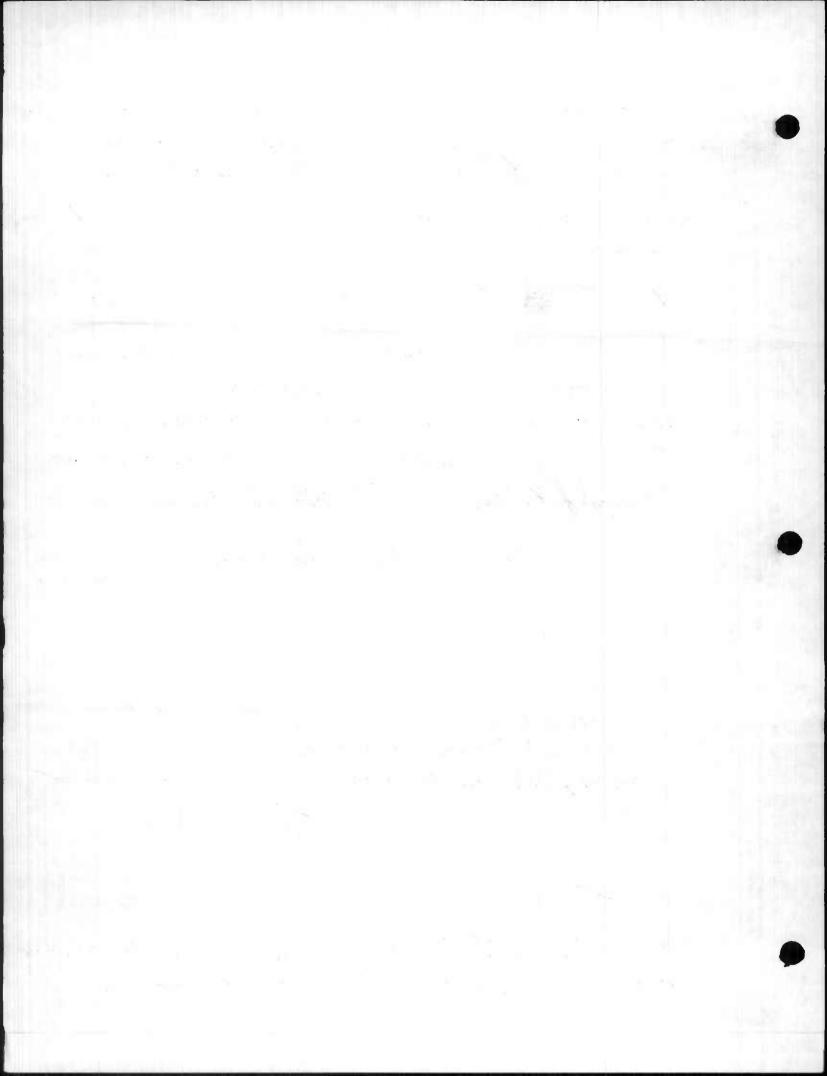
State of Maryland / Department of Health and Mental Hygiene 98 29261

				Certifica	ate of	Death		P	leg. No.		
	1. Decedent's Neme (First, Middle, L	.ast)						2. Dete of Dee	th	Vi-i-	3. Time of Death
Physician	MILDRED	c.			POLSE	CI		Month SEPT.	Dey 19	Yeer 1998	2:36 PM
/Medical Examiner	4e Fecility Neme (If not institution, g						wn, or Loc	cation of Deeth	4c. County		2.30 FM
Examiner	7121 PARK HEIGHT	S AVE., AF	т. 110	Wille	44		LTIM			N/A	
Funeral Director	5. Social Security Number 6. 215–22–2598 Usuel Residence of Decedent	Sex 7. Ag	ge (In yrs. lest birth	rs. Month	der 1 Year is Deys	If Under Hours	Min.	8. Dete of Birth (Month, De) OCT 4	1907	Coun	leca (State or Foreign try) ARYLAND
5-0020 72 hours after death with the Maryland natural; or items 23s or 28s-f show teal Examiner must be notified at sted by Funeral Director	10a. Stete 10b. County		10c. City, Town	or Location						10	0d. Inside City Limits 1 □ Yes 2 □ No
	MD	N/A		BALTIM							***
	10e. Street end Number 7121 PARK HEIGHT	S AVE., AF	т. 110	10f. 2	Zip Code 21	.215			10g. Citizen of V USA		itry?
The 2	11. Meritel Status	12. Wes Decedent	Ever in U,S.	13. Was De			gin? (Spe	cify Yes or No- Rican, etc.)		a - Americ	
o20 urs after death v al', or items 234 Eventuer man	Widowed 4 □ Divorced	Armed Forces 1 Yes 2 1 Yes, Give Yeer or Detes:			pecify Cub 2 XNo		i, Puerto I	Rican, etc.)	Specify	ck, White,	etc. VHITE
21215-0020 d within 72 hours at glene. The metural; or the metural; or the metural from	15. Decedent's (Specify only highest g	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working						16b. Kind of Bu	siness/Inc	dustry	
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faryla 2 should and Men is merke	19e. Intorment's Name/Reletionship	(Type, Print)	19b.	Meiling Addre	ess (Street	end Numbe	er or Rure	I Route Numbe	r, City or Town,	Stete, Zip	Code)
e, N 1 and 1 and Health Am 27 ther tr	MRS. BETTY FINK	(DAUG.)		2811 LA		700D C	T	BALTO.	, MD 2 20c. Location -		um Clate
Page Page Int: If Iny or	20e. Method of Disposition 1 🛣 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) BALTIMORE HEBREW 9/23/							BALTIM			
Baltim permit. Pag Department Important: any injury o	21. Signeture of Funeral Service Lic	ensee						OS., IN		LE, N	4D 21208
	23a. Pert1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one ceuse on each I	d the death. Do n	1							Approximete Intervel Between
Physician /Medical Examiner	immediate Ceuse (Finel disease or condition resulting in deeth)	e. Wrene	Due to (or es e c							1	Onset end Death
760, be axecuted lician and burial-transit cal Examiner		■ b	Due to (or es e c	consequence o	of):					1	
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Sor requirements show	24e. Wes en eutop performed?					en eutopsy med?	ev	ere autopsy tindings ellable prior to mpletion of cause deeth?			
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of Vital Ri Physician: The I this certificate harral director, page	25. Wes case referred to medical exeminer?				100		ot Deeth	(Check only o	ne)		
Physic this of rall direction 1. To			ent 2 ER/Out		DUA				lenca 6 □Oth		(y)
Vision of Attending P at death. ector: After the type the funeral tiffication:	27. Menner ot Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigate	28e. Dete of Injury (Month, De	ey Yeer) 28b. T	ime of njury M	28c. inju Wo	ryet rk?]Yes 2□		28d. Describe how injury occurred			
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Division or to the Hospital or Attending Physician 24 hours after death. To the Fuerel Director: After the completaly filled in by the funeral Medical Certification:		Physician: To the best aminer: On the basis of end menner si	at exemination and								
To the vithin To the comple	29b. Signeture end title of certifier				29c. Licen	se number			29d. Date signe	d (Month,	Dey, Year)
					9/21/9	8					
5	30. Neme end address of person wh										
	Richard A. Berg , 4D	; suite 450:		is Ral; L	Mer.	lle, ha	2100	33			
State Registrar	31. Dete filed (Month, Dey, Year) SEP 2 4 1998	Se, Hegist	rer's Signeture	do	1.1						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month **Physician** Eleanor Leona Quattrocche September 22 1998 5:05 A.M. /Medicai 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Mariner Health of Forest Hill Harford Forest Hill 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dex. Year)
April 30,1914 Maryland 9. Birthplace (State or Foreign Funerai Months Days Hours Yrs. 213-09-6729 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21231 204 S. Castle Street USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Biack, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. Elementery/Secondary (0-12) College (1-4or 5+) 4th Cleaning Utilities Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Krysiak Mary Kaliszak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Wancowicz / Daughter 108 Bayland Dr. #3 Havre de Grace, Maryland 21078 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus 9/25/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) e of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Home 401 S. Chester Street Baltimore, Maryland 21231 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last physician end the bunel-tren Due to (or es e consequence of): ре вхес P.O. Box 68760, Physician/Medical Due to (or as e consequence of): use as 5 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the causs of death? signed by t Severe Cachexia 1 Yss 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? Percutaneous Endoscopic 25. Was case referred to medical examiner? For Poor Oral Intake 1 Yes 2 No 1 Yes 2 No this certificate Division of Vital 26. Piece of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA 1 Yes 2 No 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Affer 1 -Natural 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours efter death Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital or A within 24 hours efter To the Funeral Direct completely filled in b edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Tier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and does not accept a literature. So that basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature end fitte of certifier 29c. License number 29d. Dete signed (Month, Day, Year) ND 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) & Law Street, Aberdeen MANUEL 4ZATIN 31. Dete filed (Month, Day Year) SEP 2 4 1998 32. Registrer's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene 98

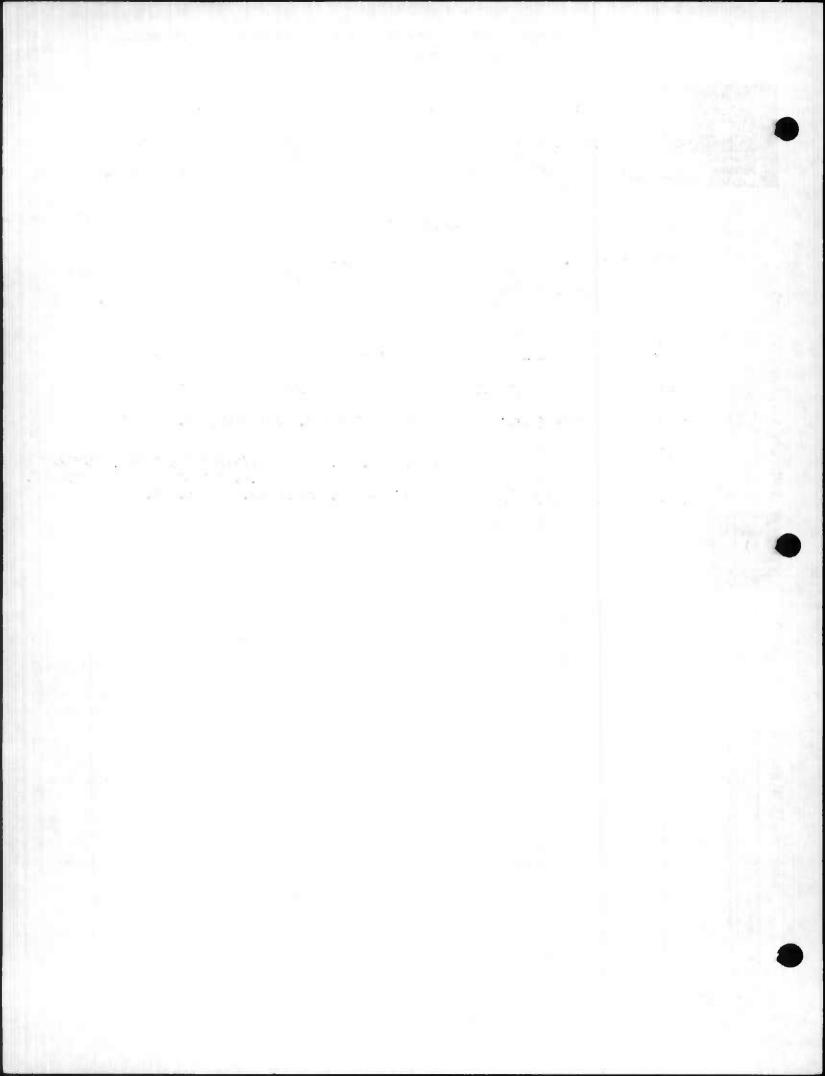
Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Time of Death Month **Physician** 9.30.Am IREDELL ROBERTS g 18 1998 /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MANOR CARE ROLAND PARK BALTIMORE N/A If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Yaar) 6 6 17 7. Aga (In yrs. lest birthday) 9. Birthplaca (Stata or Foraign **Funeral** Months Deys Hours XX M 2 F NORTH CAROLINA Yrs. 238-18-7909 81 Director Usual Rasidance of Decedant the Marylend 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumatic event, the Maxical Examiner must be nottled at MXYes 2 □ No Director MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10q. Citizan of What Country? with US 1705 McKEAN AV. 21217 Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxicen, Puarto Ricen, etc.) 11. Marite! Status 14. Race - American Indian, Black Whita, etc. 72 hours efter XIX Yas 2 □ No If Yas, Give Yaar or Datas: 1 ☐ Navar Marriad 🏋 🖾 Married Saltimore, Maryland 21215-0020 1 Yas XXNo Specify: BLK. by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/industry of filed within 73 el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LABOR STEEL 10 permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked othe any fijury or other traumatic event. 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Be LITTLEJOHN MALACHIA ROBERTS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1705 MCKEAN AVE. BALTIMORE, MD. GERTRUDE ROBERTS (WIFE) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Burial 2 Cramation 3 Removel from Stata Donation 5 Othar (Specify) 9/24/98 BALTIMORE, MARYLAND ARBUTUS MEM. PK. 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility E.L. PHILLIPS FUNERAL HOME PA. CFSP Hecto 1721-27 N. MONROE ST. BALTIO., MD. 21217 23a. Part1. Entar the disaasa, or complications that caused tha daath. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximata intarval Batween Onset and Deeth Physician /Medical Immediate Causa (Final disaasa or condition resulting in deeth) Prostatic Cancer Examiner Dua to (or as a consaquance of): Examine disease oronan 9 TARTI Sequantially list conditions, if any, laading to immediata causa. Enter Undartying Causa (Disaase or injury that initiated avants pue Dua to (or es a consaquance of): Consestice Cardio myo pathy Physician/Medicai thet initiated avants resulting in daeth) Last Dua to (or es e consequence of): engestile Failure, neart Box Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown by 24b. Were eutopsy findings availabla prior to complation of ceuse of deeth? 24e. Wes en eutopsy performed? Completed peen hes page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Physician: 25. Wes case refarred to medical axaminar? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 21XNo Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day Year) 27. Mennar of Deeth 28d. Dascribe how Injury occurred 28b. Tima of Injury 28c. Injury at Work? I or Attanding Fafter deatn. After 1 Natural 5 Pending after deatn. Director: Aft 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be detarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida the Hospital cannot be funded in pletely filled 15d Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

21 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifiar Medicai (Check only one) within 2 To the 29b. Signatura end title of certifian 29c. License number 29d. Data signed (Month, Day, Year) 30115 30. Nama end address of person who completed causa of daath (ttam 23a) (Type, Print) Ohiokpehaimo 2600 LIBERTY HEATS AVE BAIL MORE MO ZIRIS 31. Data filed (Month, Day, Year) 32, Ragistrar's Signature SEP 2 4 1998

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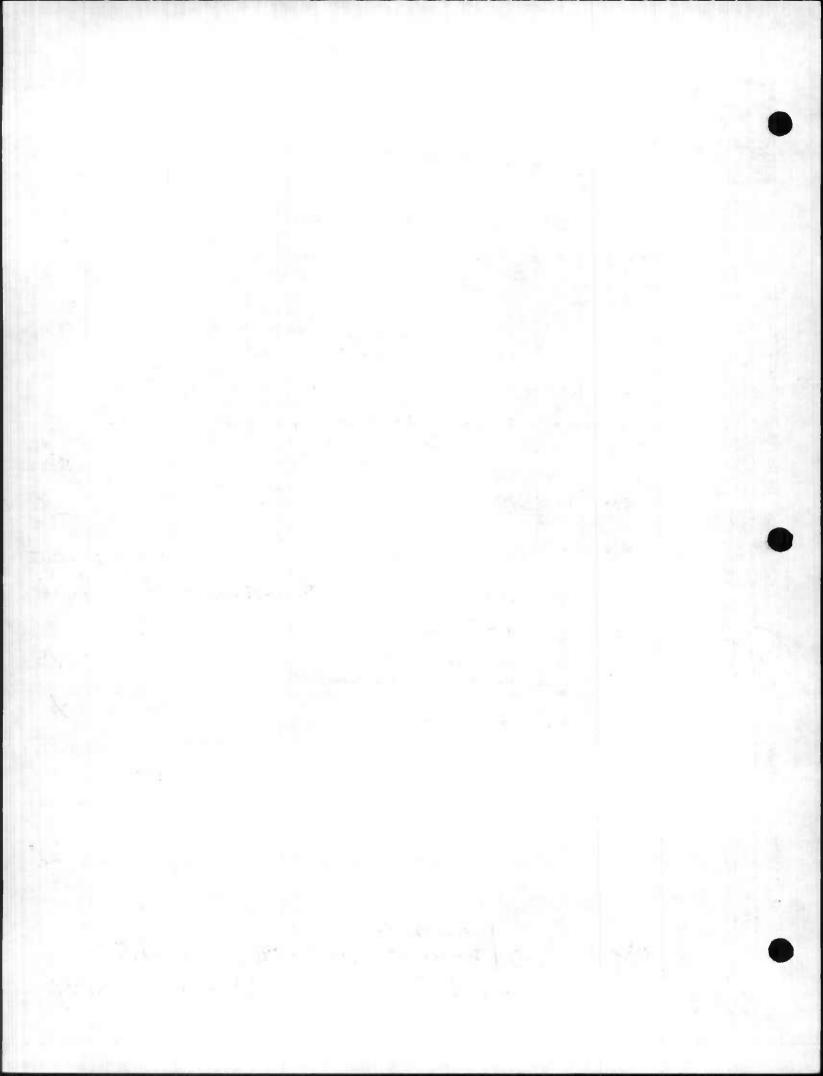
DHMH 16 Rav 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 8 2 9 2 6 4

	C	ertificate of Death	Reg. No.	C J L U 9
	1. Decedent's Neme (First, Middla, Last)	2	2. Data of Death	3. Time of Death
Physician	ANITA . M. RUTKOWSKI	<	EPTEmber 21, 19	8:30 P
/Medical Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Loca		
LAUTHILL	6220 FAIRBAKS AVE	BALTIMORE,	CITY NI	A
uneral	5. Sociel Security Number 6. Sex 7. Aga (In yrs. last birthd	ay) If Under 1 Year If Under 24 Hrs. 8	Data of Birth	Birthplace (State or Forei
Director	219-50-3348 1 M 200 F 50 Yrs	Months Days Hours Min.	(Month, Day, Year) - PAIL 23,1948	Country) M.D. 6
8 m	10a. Stata 10b. County 10c. City, Town or	Location		10d. Inside Çity Limi
vith the Mary or 28a-f sh be notified Director		ETIMORE IMD.		1 2 Yas 2 0
Sa or 2	10e. Street and Number 6220 FAIROAKS AVE	10f. Zip Code	10g. Citizen of What	Country?
natural', or Name 23a or 28a-f show deal Examiner must be notified at steel by Funeral Director	3	0		merican Indian,
	11. Marital Status 1 Naver Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedant Ever in U,S. Armed Forces? 1 Yas, Give Yaar or Datas:	Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Maxican, Puerto Ri Yas 2 No Specify:	Cassifu	Thita, atc.
or than "natural", t, the Madeal Ear Completed by	15. Decedent's Education (Specify only highest grade complated) 16a. De	cedent's Usual Occupation iva kind of work done during most of working	16b. Kind of Busine	ss/Industry
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ther than	O N/n	NEVER WORKED	NIA	
9 9	17. Fathar's Name (First, Middla, Last)	18. Mother's Name (First, Middle, Maiden Surname)	
arked certic ev	JAMES RUTKOWSKI	GERTRUD	E B. BEH	R
e u		ailing Address (Street and Number or Rural I	Route Number, City or Town, Stat	e, Zip Code)
om 27 is other tre	JAMES RUTHOWSKI (FATHER) 628	20 FAIROAKS AVE, BY	ALTO, MD 212	14
E	20a Method of Disposition 20b Place of Di	sposition (Nama of	Data 20c. Location - City	
TY OF C		HEART of JESUS 9	25/98 ROLTO	CO MA
ortant: injury B.	21. Signature of Funeral Sarvice Licensee	22. Nama and Address of Facility	0110	100.10
importar eny injui pnce.	Datter Willer.	HARTLEY MILLER T	FUNERAL HOME	CHID.
	23a. Part1. Enter the disease, oNcomplications that caused the death. Do not shock, or heart failure. List only one cause on each line.	7527 Hasford RD	BALTO, MD 21	234
a the document and the	Immediate Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last	sequence of):	c (wor)	cowwa
3	d. H+ Seizory			50,5
atached for us etached for us Physician/	e. He Sucre Me	the retardedis		
ysi ys	Part II. Other significant conditions contributing to death but not resulting in the	a undarlying causa given in Part t.	23b. Did tobacco use contrib	ute to the cause of de
	que co Above		1 Yes 2 No 3	Probably Unk
page 2 should be d			24a. Was an autopsy performed?	b. Ware eutopsy finding available prior to completion of cause of death?
sgs 2 sgs 2 omp			1 Yes 200 No	1 ☐ Yes 2 ☐ No
	25. Was case referred to medical	26 Blace of Death /		
Srector Srector O Be	examiner? Hospital:	26. Place of Death (Contract Con
2 - F	27. Manner of Death 1 Patural 5 Panding (Month, Day Year) 28b. Time Injury	a of 28c. Injury at 28	a 5 Aasidence 6 □ Othar (5 Id. Describe how injury occurred	ipecity)
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非日 権	29b. Signatura end titla of certifiar	Ana 29c. License number	29d. Data signed (M	onth, Day, Year)
200	Mary 1 Comment	4	G1. 100	,
	My chawd N) Prokrywk	N DOD 52846	7/23/78	,
5	30. Name and address of person who completed causa of death (Itam 23a) (Typ	be, Print)	11.	2
/	2914 9191 -	soma Rd; Bi	Hivery MA	21234
State	31. Dele filed (Month, Day, Year) 32. Registrar's Signatura	10	, (
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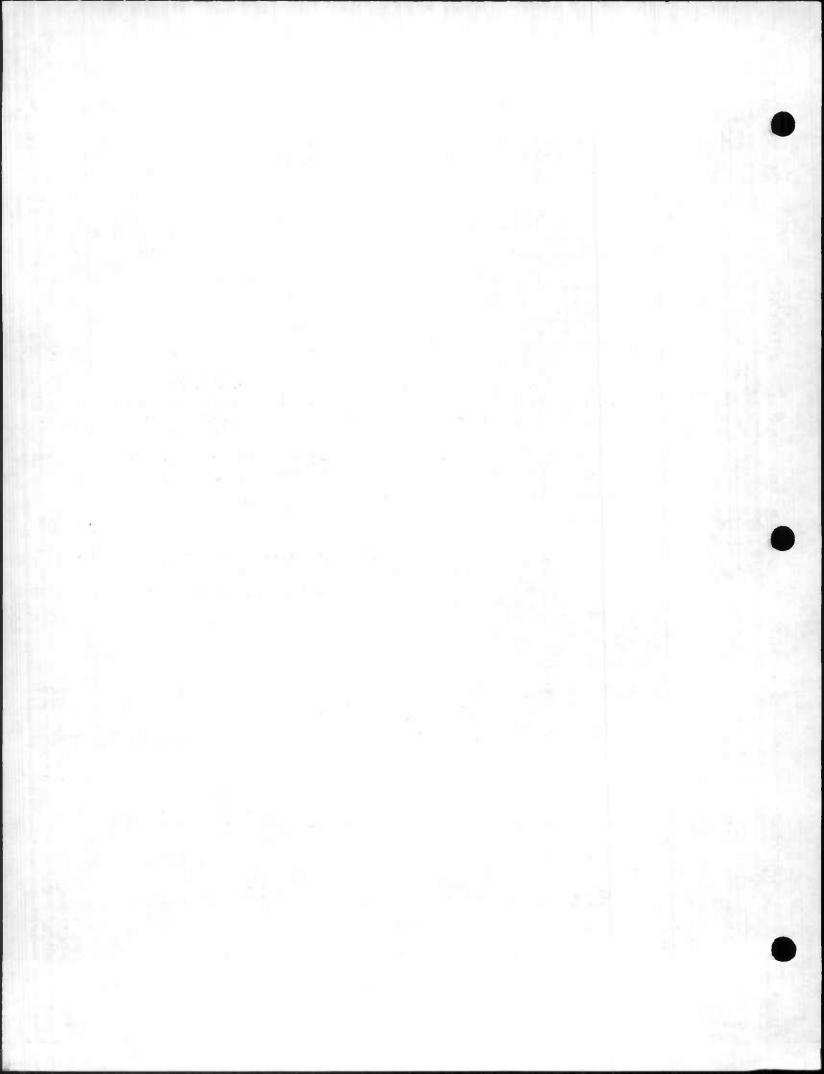
SHUGH - ELIZABETH A.

		State of Marylan	· ·	t of Health and e of Death		giene 8	29265	
Dhusisian	1. Decedent's Neme (First, Middle, L.				2. Date of Dea Month	th Day	3. Time of Death	
/Medical		Elizabeth A	. Shugh	T	Seplembe	er 25	1998 6.26 MM	
Examiner	4a Facility Name (If not institution, gi		SPITAL	4b. City, Town,	or Location of Deeth	4c. County	. 0 -	
Funeral Director		Sex 7. Age (In yrs. 1 M 2 X F 74	22.2.2.2	1 Year If Under 24 H Days Hours M		Year)	Birthplace (State or Foreign Country) Maryland	
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0 8 0	10e. Street and Number 8462 Church Roa	đ	10f. Zip	Code 21122		10g. Citizen of V	· ·	
ma 2 rema	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	,S. 13. Was Deced	ent of Hispanic Origin?	(Specify Yes or No-	14. Rac	e - American Indian,	
by by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	U,S. 13. Was Decedent of Hispanic Origin? (Specify Yes or if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify:			Black, White, etc. Specify: White		
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0 8		John J. Haspert			Susanna M	ildenbe	rger	
amme	19a. Informent's Name/Relationship		19b. Mailing Address	(Street and Number or				
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	4 Donetion 5 Other (Spec		ly Cross Ce	metery d Address of Facility	9/26/98	Baltim	ore, Maryland	
any Ir	21. Signature of Funerel Service Lice	Funeral Home P.A.						
Nainn	23a. Part Enter the disease, or constant shock, or heart failure. List or the constant shock is the constant shock of the constant s	his dions that caused the deat ceuse on each line.	PWI.E.	itchie High	_		Md • 21225 Approximate Intervel Between Onset and Death	
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of for u	Part II Other significant conditions	contributing to death but not rea	ulting in the underlying o	auco civon in Part I	23h Did 6	obacco use co	ntribute to the cause of death?	
y Phys	Part II. Other significant conditions	contributing to death but not res	uiting in the underlying c	ause given in Part I.		The state of the s	3 Probably 4 Unknown	
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d in by II	3 ☐ Suicide 6 ☐ Could not 6 determined	28e. Plece of Injury - At h building, etc. (Specil	iury - At home, farm, street, factory, office 28f. Locati c. (Specify) 28f. Locati				per or Rural Route Number,	
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comp	29b. Signature and title of cartifier			:. License number		29d. Date signe	d (Month, Dey, Year)	
X	30. Neme end eddress of person who	MEDICAL)		D0052	277 !	SEPTEMBE	TR 2320 1998	
0	FRANCIS KNIACH	TE ATTIOGRE	NORTH	TRUNDE	HOSPIT	AL M	ARYLAND.	
State	31. Date filed (Month, Dey, Yeer)	32. Registrer's Signal						

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Department of Health and Mentel Hy
Important: If Nem 27 is marked other
any Injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Alvena M. Kilev 2 James J. Stewart Sr. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Cynthia Acosta daughter 1085 Woodlawn Avenue Pasadena, Maryland 21122 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete 9/25/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Holy Cross Cemetery 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Gonce Funeral Home P.A. namuseur 4001 Ritchie Highway Baltimore, Md. 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last nquence of) P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b Records, by 24b. Were autopsy findings available prior to Completed 24e. Wes an eutopsy performed? peen completion of cause of death? has 1 Yes 20 No 1 Yes 2270 certificate Division of Vital al or Attending Physician: T s after deeth. Il Director: After this certificat ed in by the funeral director, p Be 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 8 Other (Specify) Certification: To 1 Yes 200No 28a. Dete of tnjury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Neturel 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Di Hospital To the Hospi within 24 hou To the Funer completely fil Medical 29e, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) 30. Name and address of person who combleted cause of death (Item 234) (Type, Print) Dr. Sidney Gehlert 1600 Crain Highway Suite 208 Glen Burnie, Md. 21061 31. Dete filed (Month, Dey, Year) SEP 2 4 1998 32. Registrer's Signeture Registrar



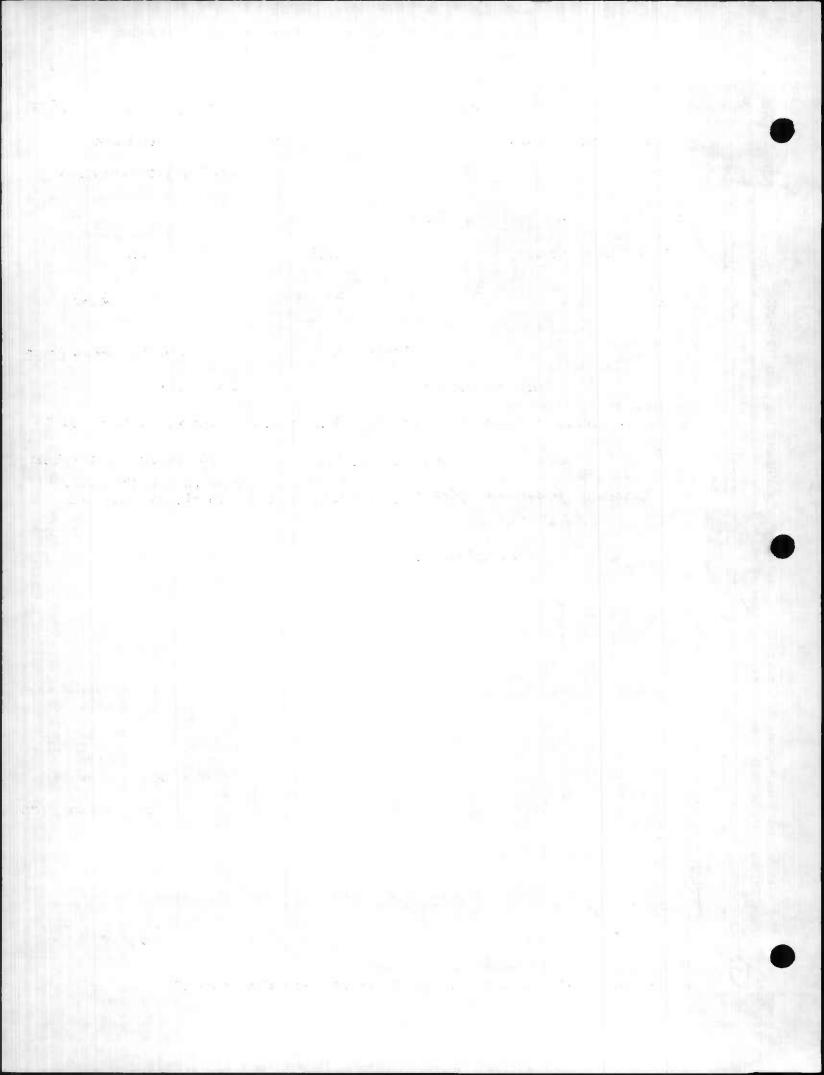
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death. 1. Decedent's Name (First, Middle, Last) Month Day Year 25 **Physician** September 19, 1998 cation of Deeth 4c. County of Death 1998 PM SKIERKOWSKI FREDA /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) Examiner Stella Maris Hospice Towson If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number if Under 1 Year Birthplaca (Stete or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Days 1 M 2 X F Months 214 01 7305 79 Yrs. July 16, 1919 Director Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location r 28a-f shov 1 NYes 2 No Maryland N/A Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "natural", or items 23a or adical Examiner must be a 1029 Church Street 21225 II.S. Pages 1 and 2 should be filed within 72 hours efter death tent of Health and Mentel Hygiene.
nt: If Item 27 is marked other than "natural", or Itema 23. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: g White 3 Widowed 4 Divorced the Medical Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Sales Lady 6th Epsteins Dept. Store ed other 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) marked Benjamin Olescuk Phyllis Wallis 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 99 Carolyn Parsons / daughter 320 White Rocks Court Pasadena, Maryland 21122 item 2 Baltimore. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Depertment of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from Stete 9/23/98 Holy Cross Cemetery Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Gonce Funeral Home P.A. lecome manuaurelle 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final BREAST CANCER disease or conditio resulting In death) Examine Due to (or as a consequence of): Examiner the death certificate be executed and Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical Due to (or as a consequence of): 80 for use es signed by the e 23b. Did tobacco use contributa to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Division of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown that by The lew requires 24b. Were eutopsy findings evalleble prior to completion of cause of death? should 24e. Wes an autopsy Completed is certificate hes director, page 2 1 Yes 2 No 1 Yes 2 No Attending Physician: 25. Was cese referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE P 1 Yes 2 No this 28a. Date of Injury (Month, Dey Year) funeral Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 XNaturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours efter Funeral Dire letely filled in b 6 Hospital 1X Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner es stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature a 60005 9:19.48 ed 30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print) DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 16 Rsv 6/95

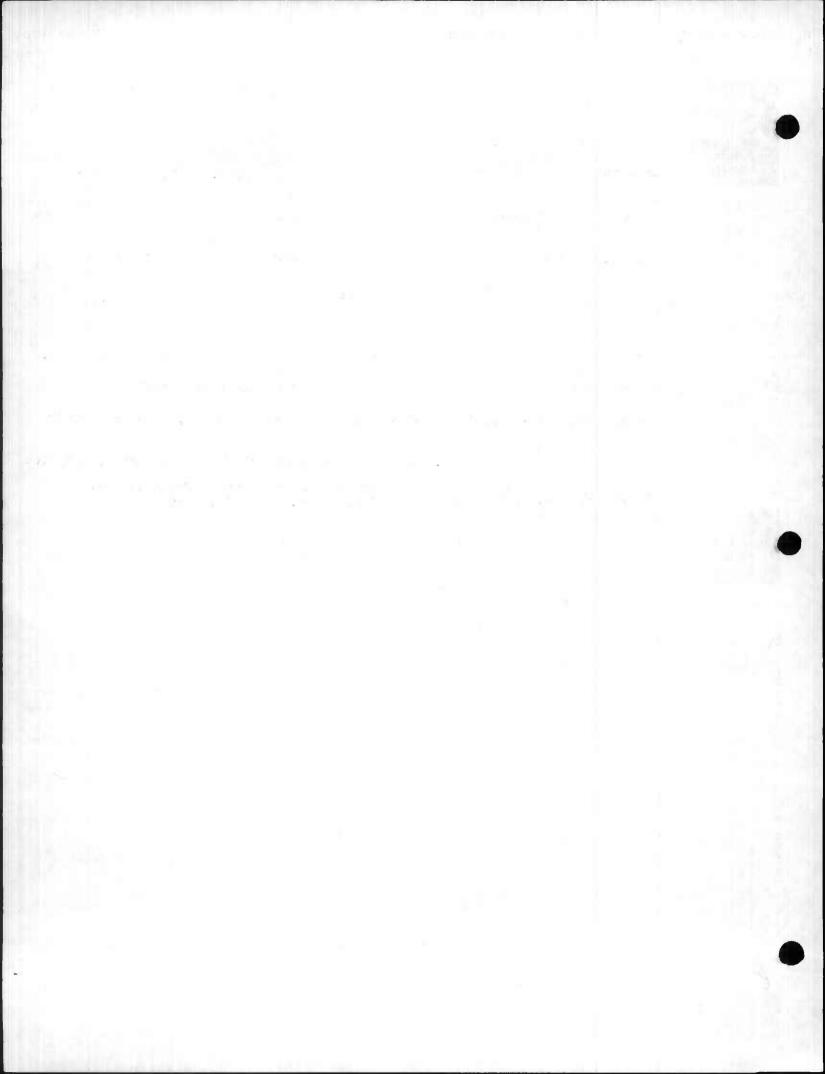
State Registrar 31. Date filed (Month, Pey Year) 1998

32. Registrer's Signature



	Decedent's Name (First, Middle, La	eri		Certificate of	Death	2. Dete of De	Reg. No.		3. Time of Deeth
ian cal	DORDTHY	317		SIBISK	-(Month SEP1	Day	Year G98	09:30 PM
ner	4a. Facility Neme (If not Institution, giv		1 1160	as Course	4b. City, Town, or L BALance				
_	JOHNS HOPKENS 5. Social Security Number 6. S		(In yrs. last bi	THORAY If Under 1 Year			N/A		no /State or Fernian
		IDM 2√2 F 72		Yrs. Months Days		(Month, De	7, Year) 12,1926	Country Mary	e (Stete or Foreign Land
	10a. State 10b. County		10c. City, Tov	n or Location				10d	I. Inside City Limits
tor	Maryland Ba	altimore			Dundalk				1 ☐ Yes 2 🕅 🗓 Xo
Director	10e. Street end Number			10f. Zip Code			10g. Citizen of W	hat Country	n
rai	6809 Duluth Avenu	ıe			21222		Unite	d Sta	tes
by Funeral	11. Maritel Stetus 1 Never Married 2 Married 3124Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2511 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub		pecify Yes or No Pican, etc.)	14. Race Blec Specify	- American k, White, etc	
	15. Decedent's Ed	ducation	16a	. Decedent's Usuel Occu	pation		16b. Kind of Bu		
Completed	(Specify only highest gre Elementary/Secondary (0-12)	ede completed) College (1-4or 5-	+)	(Give kind of work done life. DO NOT use retire	a during most of work ad)	king			
Con	7 Years			Cafeteria W	1				ing Co.
Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			*	
70	John Skotarski 19a. Informant's Name/Relationship (Time Print)	101	o. Mailing Address (Stree			zepaniak		a da l
	Madeline Mack	(Daughter)		8190 Gray H					21222
	20a. Method of Disposition		20b. Place of	f Disposition (Neme of		Date	20c. Location -		n, State
	Bunal 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specific			ry, crematory or other ple tanislaus C		/26/199	8 Balti	more.	Maryland
	21. Signature of Funeral Service Liger		50.	22. Name end Addr Duda-Ruck					
	Vht.VI	Home		Duda-Ruck 7922 Wise			Dundalk Maryland		
	23e. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused	the death Do					A	pproximate
	Shook, or house failure. List only		0						nterval Between Onset and Death
	Immediate Cause (Final disease or condition resulting In death) MYOCARDIM (NFANCO)								2 hours
_	resulting In death)	I.	Due to (or as a	consequence of):	-				
Examiner		0.	PSIS						
Exa	Sequentially list conditions, if any, leading to Immediate cause. Enter Underty program of the Course Course Course (Disease or Injury Co. PEUPHERAL VATCULAR DISEASE								
edicai	thet initiated events	G		consequence of):	Mr 12/19	ास ८		-	
	resulting in death) Last			1 1.0-3-0	4 DISE	ASE			
an/N		d	LONA	y Anten	7 000	1100			
SICI	Pert II. Other significant conditions co	ontributing to death bu	t not resulting i	n the underlying cause gi	iven in Part I.	23b. Did	tobacco use con	tribute to th	ne cause of death?
Physician/M								3 Probab	bly 4 Unknown
þ	Chier les locas	LIVER	11 2016	. 10-1				041 111	
Completed	Ethonic REMPI INSUFFICIENCY 11 Yes 20 No 24a. Was an autopsy performed?						availa	eutopsy findings able prior to pletion of cause	
DE C						45	Yes 212 No	of de	
Be C	25. Was case referred to medical				28. Place of Dee	th (Check only o		101	res 211 No
0	exeminer?	Hospital:	nt 2 ER/O	utpatient 3 DOA Ot	hoe			or (Specify)	
tion: T	27. Menner of Death 1 SNaturel 5 Pending 2 Accident Investigation	Menner of Death 1 Shaturel 5 Pending (Month, Dey Yeer) 28b. Time of Injury at Work? 28c. Injury at Work? 28d. Describe how Injury occurred Work?							
Certification:	2 Accident 3 Suicide 4 Homicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or R City or Town, Stete)						er or Rural R	Route Number,	
4.3	29a. Certifier (Check only one) 1 Certifying Physical Examples (Check only one)	niner: On the besis of a	examination ar	e, death occurred at the ti	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) end ma date and place, e	nner es stete and due to th	ed. ne cause(s)
dical	(Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end du and manner stated. 29b. Signeture end title of certifier 29d. Date signed (Mon								y, Year)
Medical	29b. Signeture end title of certifier	RE	29b. Signeture end title of certifier PETUDENT 29c. License number 29d. Date signed (Monte 2						
edical	29b. Signeture end title of certifier Author	un in	SURSE	ry R	ES.000		SEPTEN	uson t	27, 1998
edical	29b. Signeture end title of certifier MMAN 30. Neme and address of person who DENTRYMENT OF SUP 31. Dete filed (Month, Day, Year)	Completed cause of de	eth (Item 23a)	(Type, Print) do btw	R. DOM. I	rup Dimni	-		

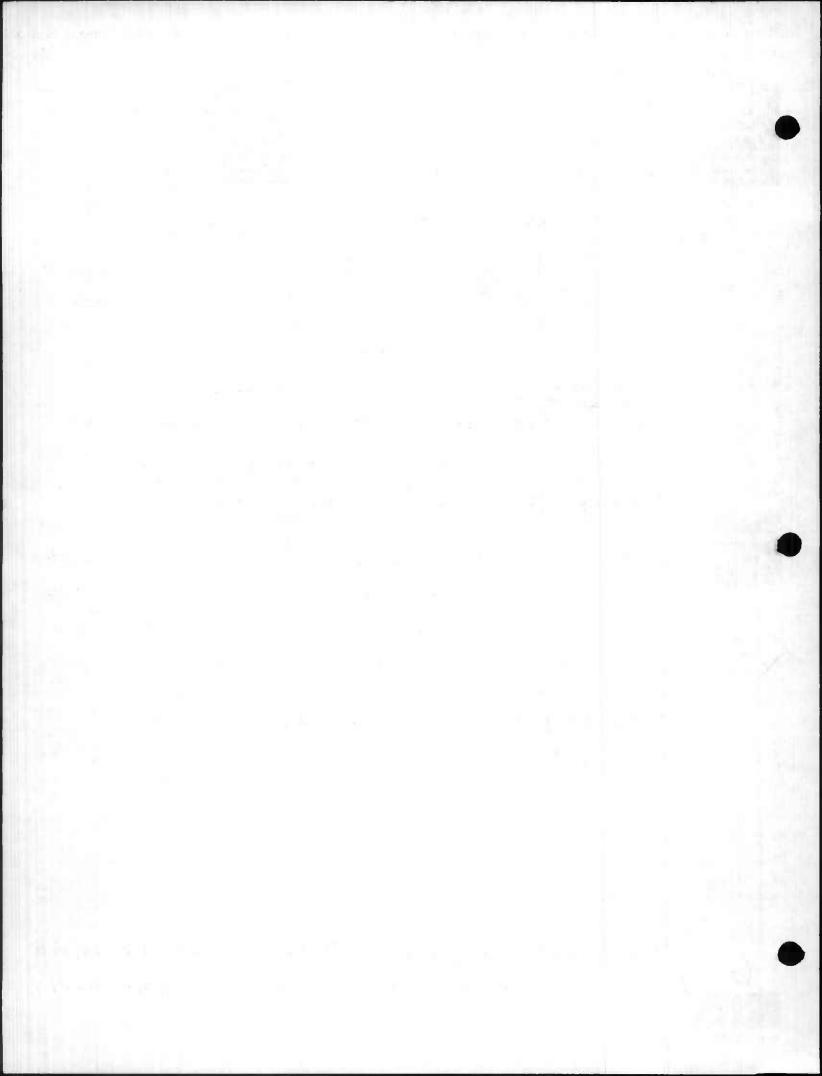
Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant'a Nama (First, Middla, Last) 2. Data of Death **Physician** Month Seiders Edna September 22 1998 1322 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore N/A If Undar 24 Hrs. 8. Data of Birth (Month, Day, 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1□ M 2∰F Director 213-74-6102 93 26 1904 Usual Rasidance of Decedant with the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show the principle of the profiled of th 1 ☐ Yas 2 No Director Baltimore Edgemere 10e. Street and Number 10f. Zip Coda 10g. Citlzan of What Country? 3010 Delmar Ave 21219 USA 12. Was Decedant Evar In U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 21215-0020 1 Yas 2X No Specify: Completed by Specify: White 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Dacedant's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) Elementery/Secondary (0-12) Collega (1-4or 5+) Housewife Own Home Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be William Dennis Laura Langley 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Robert I. Seiders /son 1518 St. Mary's Rd Chester, MD 21619 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition Sept 25 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Meadowridge Memorial 1998 Baltimore, MD 21. Signatura of Funeral Sarvica Licensaa 22. Name and Address of Facility
Connelly Funeral Home of Dundalk oct 7110 Sollers Point Rd 23a. Part1. Entar tha disaar or complications that caused tha daath. shock, or haart failura list only ona causa on aach lina. po not antar tha mode of dying, such as cardiac or respiratory arrest, Approximeta Intarval Between Onsat and Death Physician /Medical Immediata Causa (Final minutes Cardiac failure disaasa or condition resulting in daath) Examiner Due to (or as a consaquanca of) Examiner metabolic acidosis Saquantially list conditions, if any, leading to Immadiata causa. Enter Underlying Causa (Disaasa or Injury that initieted evants resulting in daath) Last Dua to (or as a consaquanca of) and facture Records, P.O. Box 68760 acute renal Physician/Medical Dua to (or as a consequence of). aortic stenosis severe The law requires that the deap Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown atrial fibrillation disease, by 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was en autopsy performed? anemia, gout this certificate has 2 NINO Division of Vital the Hospital or Attending Physician: Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Impatlant 2 ER/Outpatiant 3 DOA 27. Mennar of Death 28c. Injury at Work? Certification: 28b. Tima of 28d. Describe how Injury occurred After 5 Panding Invastigation 1 Natural death. 1 Yas 2 No 2 Accident Diractor: in by the 3 Suicida 6 Could not be datamined 28a. Piaca of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) within 24 hours aftar To the Funeral Dirac 4 | Homicida 1 Certifying Physician: To the bast of my knowledge, deeth occurred at tha time, date end plece, and dua to tha cause(s) end manner es steted.

2 Madical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Cartifiar completely 29b. Signature and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) September, 22, 1998 30. Name and address of person complated causa of daath (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, Maryland 21224 Kathryn J. Eubank 31. Data filed (Mooth, Payo Year) 1998 32. Registrar's Signatura State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 10 m Else DeVeas Smith DEPTEMBER 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Hospice of Baltimore Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Months Days Hours Min. 1 M 2 KF 214-01-7617 83 Yrs. 1914 Oct. 11, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore City Baltimore 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 924 Southerly Road Baltimore 21204 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 TNo Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 0 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Franklin Ellsworth DeVeas Maggie Francis Kerchner 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Donna Watchorn/niece 7113 Heathfield Road, Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Servica Licensee S. Wade State Anatomy Board, 655 W. Baltimore Street Birector many Baltimore, Maryland 21201 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospice 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or frems 23s or 28s-f show to a Mapical Examples must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a pare.

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Funeral

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Completed

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ettending physician and for use es the bunal-transit use es t ed by the detached peeu page 2 s 105 certificete director, this

Physician/Medical Examiner þ Completed Be °E funeral Certification:

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homlcide

5 Pending

Investigation

6 Could not be determined

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician: After ! or Attending after deeth. I Director: A

> State Registrar

edicai

28b. Time of

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work?

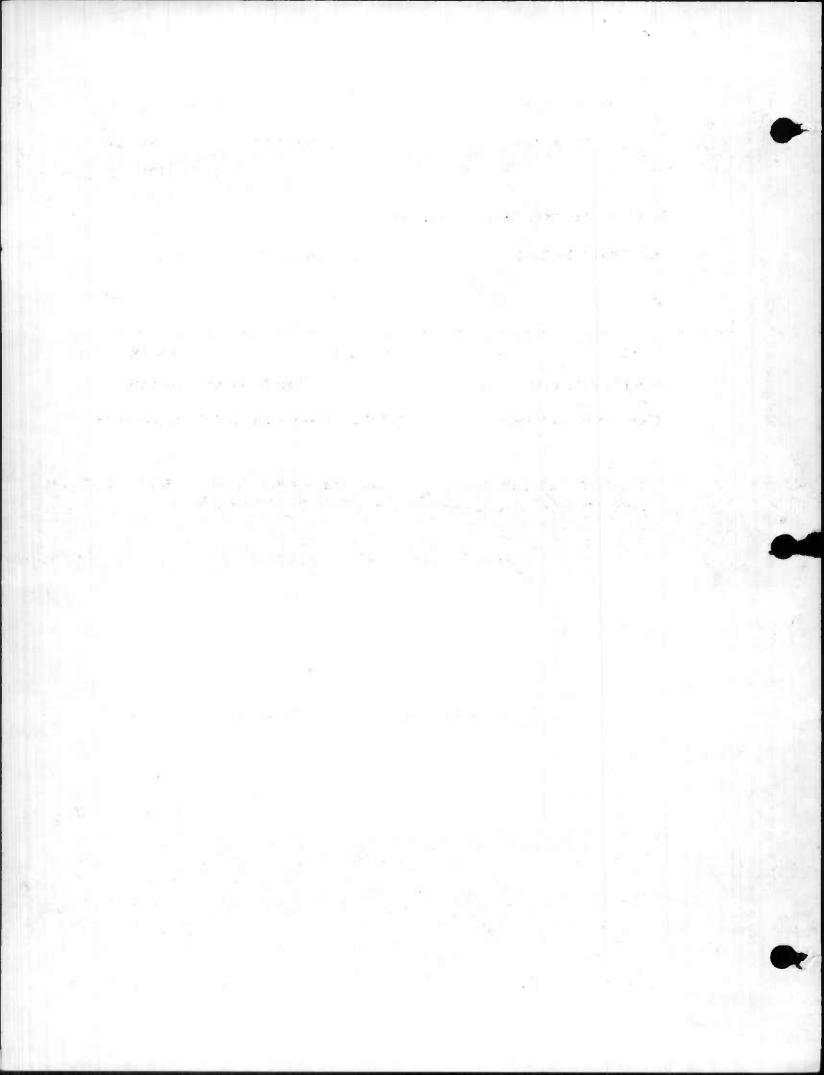
1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28a. Date of Injury (Month, Day Year)

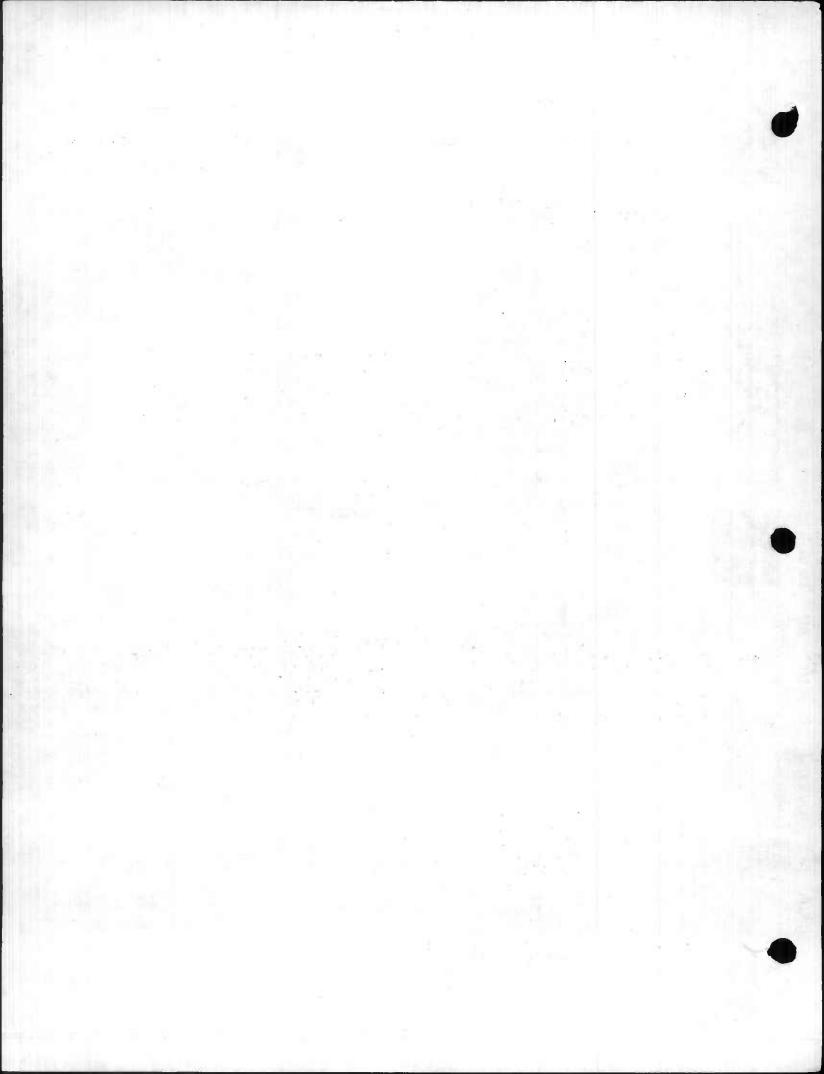
To the Hospital o within 24 hours at To the Funeral Di completely filled is



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #2 Per MD Film G764 10-23-98RC Certificate of Death Item#11 per Inf G765 11/06/98 EW Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Day 18 Year Month **Physician** Eva Marie Severn SEPTEMBER 1998 0055 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 29, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 25 F 215-07-2660 81 1917 Director Maryland Usual Residence of Decedant the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow *natural", or items 23s or 28s-f sho Maryland Wicomico Mardela Springs 1 ☐ Yas 2 ☑ No Director 10e. Street and Number 107 Main 10g. Citizen of What Country? 10f. Zip Code Street 21837 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health end Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or Hei any Injury or other traumatic event, the Medical Exercities. 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Datas: Nevar Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White by 3 🖾 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker School School Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Gough Beierlein Alice Elkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 107 Main Street, Mardela Springs, Maryland 21837 Tony Severn/son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stale 1 Burial 2 Cremation 3 Removal from State 4 ⊠ Donation 5 ☐ Other (Specify) 21. Signature of Furnital Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility. Board, 655 W. Baltimore Street Baltimore, Maryland 21201

23a. Part1 Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failura. List only one cause on each line. Onset and Death **Physician** Kespiratory FAILURE
Due to (or as a consequence of): Immediate Cause (Finat disease or condition resulting in death) /Medical Examiner NEURO MUSCULAN DISPASE Physician/Medical Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasl Due to (or as a consequence ot): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown VJOGRENS of Vital Records, by 24b. Were eutopsy tindings available prior to completion of cause of death? Medical Certification: To Be Completed 24a. Was en eutopsy performed? SEVERN 1 ☐ Yes 2 ☐ No. 25. Was case referred to medicat 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending Naturat Division 5 Pending investigation death. 1 Yes 2 No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature-and title of certifier Heur Name end address of person who completed cause of death (Item 23a) (Type, Print) On SALISBURY Md 21801 560 RIVERSIDE Floury 31. Data filed (Month, Day, Year) SEP 2 4 1998 32. Begistrar's Signatura State Registrar



Please Type or Print in Black indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Deeth September 20, 1998 8:20 am SAUBER CLAOYS City, Town, or Location of Death 4c. County of Deeth 4a Fecility Nama (If not Institution, giva straat end number) Baltimore Johns Hospita Hopkins The If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) If Undar 7. Age (In yrs. lest birthday) 5. Social Security Number Months Deys 10 M 20 F 216-16-5850 SEPT. 10 1922 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Insida City Limits 10e. State 10b. County BALTIMORE BALTIMORE 1 Yes 2 No 10f. Zlp Code 10e. Street and Number 10a. Citizen of Whet Country? 1 GRISTMILL CT., APT. 109 21208 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Meritel Stetus Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Nevar Married 2 ☐ X Arried 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) ARTIST ARTS 18. Mother's Nama (First, Middla, Meiden Sumeme) 17. Fethar's Nema (First, Middla, Last) HARRY KAHN JEAN LINKNOWN 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BALTIMORE, MD 21208 Dete 20c. Location - City or Town, State HENRY SAUBER (HUS.) 3800 OLD COURT RD. 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 1 ♥ Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetlon 5 □ Other (Specify) ARLINGTON (CHIZUK AMUNO) 9/23/98 BALTIMORE, MD 22 Name and Address of Fecility SOL LEVINSON & BROS., INC. ews 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 thet caused the deeth. Do not enter tha moda of dying, such es cardiec or respiretory errest, on each line. Approximete Intervel Between Onsat and Death Immadiate Ceuse (Finel disaesa or condition resulting in deeth) Due to (or es e consequence of): Failure Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): -ymphoma Dua to (or as a consequenca of) 23h. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause givan in Pert I. 3 Probably 4 Unknown 1 Yes 2 No Heart Failure 24b. Were eutopsy findings avellable prior to 24e. Wes en eutopsy performed? complation of causa of death? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA

/Medical Examiner Physician/Medical Examiner

Physician

Physician

/Medical

Examiner

Funeral

Director

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Certification:

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29b. Signature end title of certifies

Attending Physician: After this ector: A 6 0 F 24 hours of
 Funeral D
 Hetely filled in To the Hosp within 24 hor To the Fune completely fi

Division of Vital Records, P.O.

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State Registrar 25. Wes case referred to medical examiner? 1 ☐ Yes 2 No 27. Menner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 T Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. 29a. Certifier (Check only one)

> 29c. Licansa number MD RES-000

29d. Date signed (Month, Dey, Year) September 20, 1998

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

1000 Fell St Apt 226 Baltimore, Mary and 21231

72. Registrar's Signeture

A. 14. Allert periods parties " the parties of a partie of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle Last) 2. Data of Death 3. Tima of Death Month SEPTEMBER 20 4c. County of Death 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death HAVRE DE ar If Undar 24 Hrs. HOME CITIZENS NURSING GRACE HARFORD 5. Social Sacurity Number If Undar 1 Yaar 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 1□ M 20 F Days 220-22-8329 Yrs. Usual Rasidance of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City LImits 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 No If Yas, Give Yaar or Datas: 1 Navar Married 2 Marriad 1 ☐ Yas 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Dacedant's Education (Spacify only highast grada completed) 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Ceyes 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) 19a. Informant's Name/Reletionship (Typa, Pnht) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Sept. 20c Location - City or Town, Stata 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 23 1 Bunal 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Valley Nem. Gans 122 Nama and Address of Facility EVANS (Nafel of 2325 YORK fol 21. Signatura of Funeral Sarvice Licensas Chimes 21093 Part. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Betw Immediata Causa (Finel disaasa or condition rasulting in daath) as a consequence of) Sequentially list conditions, if any, laading to Immadiata causa. Entar Underlying Cause (Diseasa or Injury that initiated avants rasulting In daath) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Wara autopsy findings available brior to completion of ceuse of death? 24a. Was an autopsy performed? 20 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Place Deeth (Check only ona) Othar: 4 rsing Homa 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Rasidence 6 ☐ Othar (Specify) 27. Menney of Death 28d. Dascribe how injury occurred 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 5 Pandin 1 Natural 1 Yas 2 No 2 Accidant 6 Coyld not be 3 Suicide 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 4 Homicida

Box 6876 Physician/Medical Be Completed by this certificate Certification: To Director in by To the Hospital within 24 hours a To the Funeral C

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Examiner

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Director

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Baltimore, Maryland

/Medical

25. Was case referred to axaminar? 1 ☐ Yas

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar

1 Certifying Physician: To tha bast of my knowladga, daath occurred at tha tima, data and place, and due to the ceusa(s) and mannar as steted. 2 Madical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner stated.

29b. Signature and title-of certifier

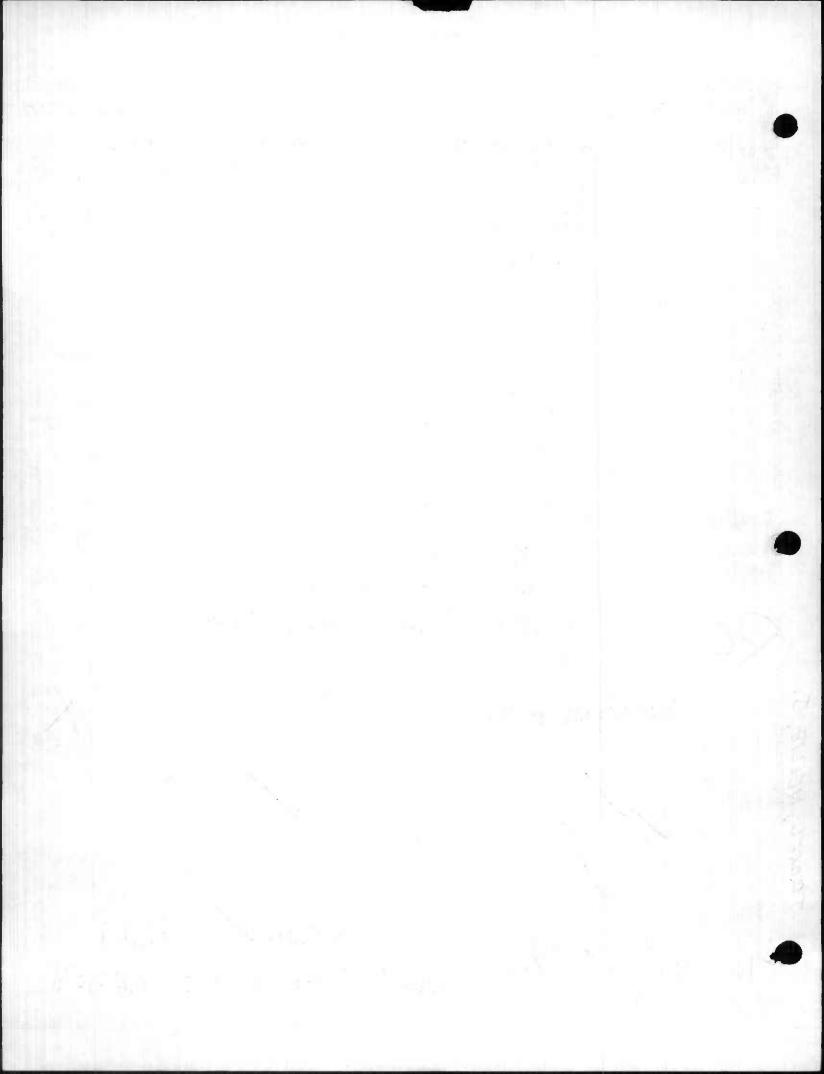
29d. Date signad (Month, Day, Year)

gause of daath (Itam 23a) (Type, P SIM 31. Data filed (Month, Day, Year)

32. Registrarts Signature SEP 2 4 1998

State Registrar

Medical



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Physician SEPT. 22, 1998 JACOUELINE TERRY 6:45am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner 3031 Elizabeth Avenue Baltimore N/A If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5 Social Security Number If Under 1 Yeer 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** Months Days 1 M 2 F 228-44-8301 62 Yrs. 05/15/1936 Director Virginia Usual Residence of Decedent 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at MD N/ABaltimore 1€ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3031 Elizabeth Avenue 21213 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Bleck, White, etc. 1 □ Never Married 2 □ Merried Maryland 21215-0020 1 ☐ Yes 20 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) Townhouse College (1-4or 5+) Housekeeper 12th Motel 18. Mother's Neme (First, Middle, Malden Sumeme) 17. Fether's Name (First, Middle, Last) in and 2 should be fill Health and Mantal Hitem 27 is marked oth Dora Widgeon Douglas Satchell 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nant of Health s Joyce A. Terry/daughter 823 Glade Court, Baltimore, MD other t Saltimore, 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 9/26/98 20c. Location - City or Town, State t Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Department of Important: If any injury or ò Baltimore, Maryland Western Star Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatual of Funerel Service Lice 22. Name and Address of Fecility LEROY O. DYETT & SON FUNERAL HOME, 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 or complications that ceuted the death. Do not enter the mode of dying, such as cardiac or respiratory errest, list only one ceuse on each ine. Approximete Interval Between Onset and Deeth **Physician** SHALL BOWEL ADBNO CAKUNOMA /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner certificata be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest bunial-tran Due to (or as a consequence of): pue Box 68760 physician Physician/Medical Due to (or as e consequence of): the SB USB 23b. Did tobacco use contribute to the cause of death? Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. Division of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown by Sign 24b. Were eutopsy findings aveilable prior to 24a. Was en eutopsy performed? Completed completion of ceuse of death? 168 21 25. Was cese referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Lo this funeral 28d. Describe how injury occurred 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Yeer) 28h Time of 28c. Injury et Work? Hospital or Attending Pin 2. hours after death.

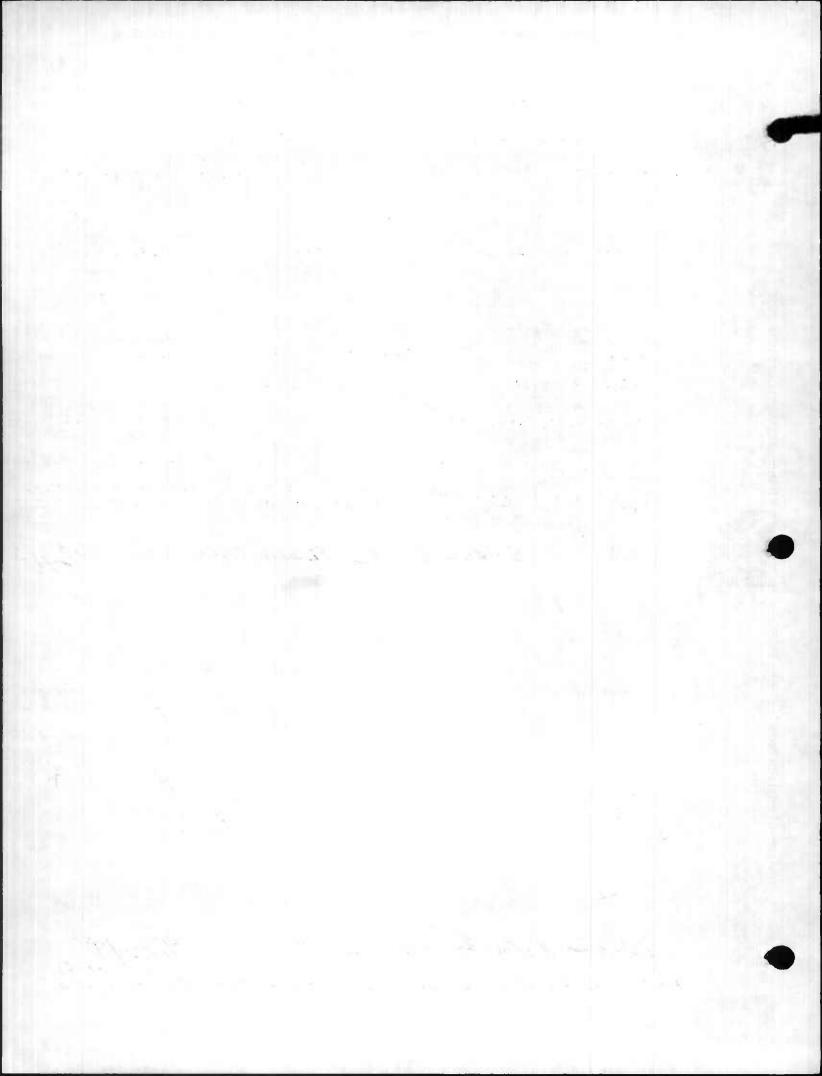
Fundal Disorder After the bletsty filled in by the funera Certification: After Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and due to the cause(s) and menner es stated.

Medicat Examinar: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) To the Within 2 To the 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 1. VAN ECHO, MY South Greens Street, Battimire

State Registrar 31. Date filed (Month, Dey, Yeer)

SEP 2 4 1998

32. Registrar's Signature



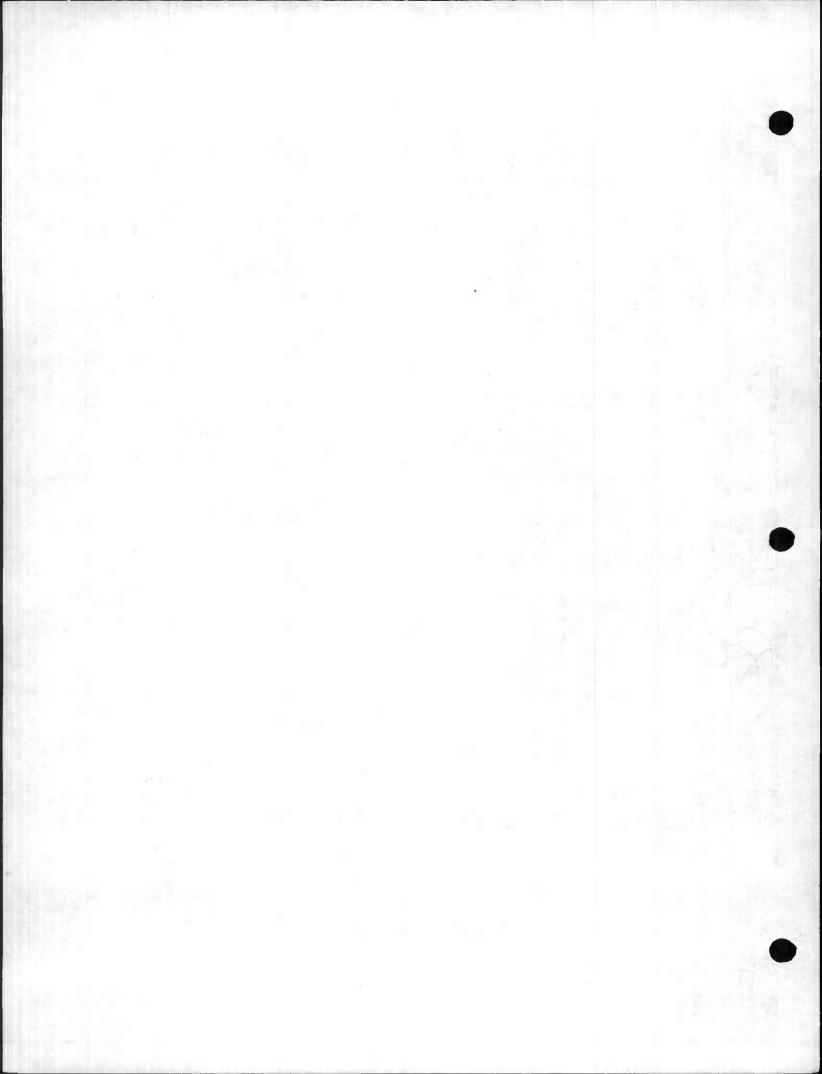
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death -7 30 11 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 8 Sai 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 10 M 20 F Months Days Hours Min Yrs. Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 1 Yes 2 No Director Mary 1010 10a. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò Nems 23a death Funeral 11 Meritel Status Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian Black, Whita, etc. e filed within 72 hours after at Hygiene.
other than "natural", or the 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if fleen 27 is marked other any injury or other treumatic avent, RDE. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burlel 2 Cremetion 3 Remove from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Facility RIG ome Nor 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) 3 months ESOPHAGEAL CANCES Examiner Due to (or as e consequence of): Examine & Years hronic Obstructive lime Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest and Due to (or as a consequence of): SPASE 000900 Due to (or es a consequence of) Box Physician/M The law requires that the destin Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 NO 1 Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes ZX No 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 2 Accident or Attanding 5 Pending investigation 1 Yes 2 No death Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) after 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as steted.

I Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted. completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 231 030115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ohlokpehairmo 2600 LIBERTY HEITS AVE BUTTIMETE 31. Dete filed (Month, Day, Year)
SEP 2 4 1998 21215 32. Régistrer's Signeture

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Deeth 1. Decedent's Name (First, Middla, Last) Month **Physician** WATERS FANNIE 21 2.50Pm 98 09 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not institution, giva straat and number) Examiner Baltimore | Undar 1 Yaar | If Undar 24 Hrs. 8. | | Months Days Hours Min. Harford Gardens Nursing Home Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foreign Country) 10M 20F Yrs. 95 215-16-0923 **Director** VA Usual Residence of Dacedan the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or itama 23a or 28a-f ahow other traumatic event, the Magical Examinar must be notified at 1 Yas 2 No Director NA Baltimore MD 10a Street and Number 10f. Zip Coda 10g. Citizan of What Country? USA 21214 4700 Harford Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian 11. Maritel Status Black, Whita, atc. 2 should be filled within 72 hours effer and Mental Hygiene. Is marked other than "natural", or its 1 ☐ Yas 2 X No It Yas, Giva Year or Detes: 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Custodian Company 12th Grade 17. Fathar's Neme (First, Middle, Last) NA 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Redd Nannie P Willie 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Intorment's Name/Ralationship (Type, Print) permit. Pages 1 and 2 sh Department of Health end Important: If Item 27 is m any injury or other traum 6613 Fair Oak Avenue Baltimore, Md. 21214 Valerie Green 20b. Placa of Disposition (Name of cematary, cramatory or other plece) 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 Burial 2 Crametion 3 Removal from Stata Loudon Park Cemetery 09-25+98 Baltimore, MD 4 Donation 5 ☐ Othar (Specify) 22. Name end Addrass of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue aloua 23a. Part . Enter the disease, or complications the value of the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one ceuse of each line. Approximata Intarval Batween Onset and Death **Physician** Cerebonovasalan accident /Medical Immediate Causa (Final diseese or condition rasulting in daath) Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if any, laading to immadiata cause. Entar Undarfying Cause (Disaasa or Injury that Initiated avants rasulling in daath) Last Dua to (or as a consequence of) Physician/Medicai signed by the ettending physical Dua to (or as a consequanca ot): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown P 24b. Wara autopsy findings available prior to complation of cause of daath? 24a. Wes an autopsy performad? Completed this certificate hes Brames 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axaminar? 26. Place of Death (Check only one) Be Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 27. Mennar of Daeth 28e. Dete of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? i or Attending Pi s efter death. I Director: After th Certification: 1 BNatural 5 Pending 1 Yes 2 No invastigation 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - Al homa, farm, straat, fectory, office building, atc. (Specify) 6 4 Homicida To the Hospital o within 24 hours of To the Funeral DI completely filled is 1 Certifying Physician: To the best of my knowledga, daath occurrad et tha tima, data and place, and due to tha causa(s) and mannar as stated. Medicai 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and piece, and due to the ceuse(s) and manner stated. (Check only one)

State Registrar

Saltimore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records.

31. Data filed (Mont Dex Year 1998

30. Nama and eddrass of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and titla of certifian

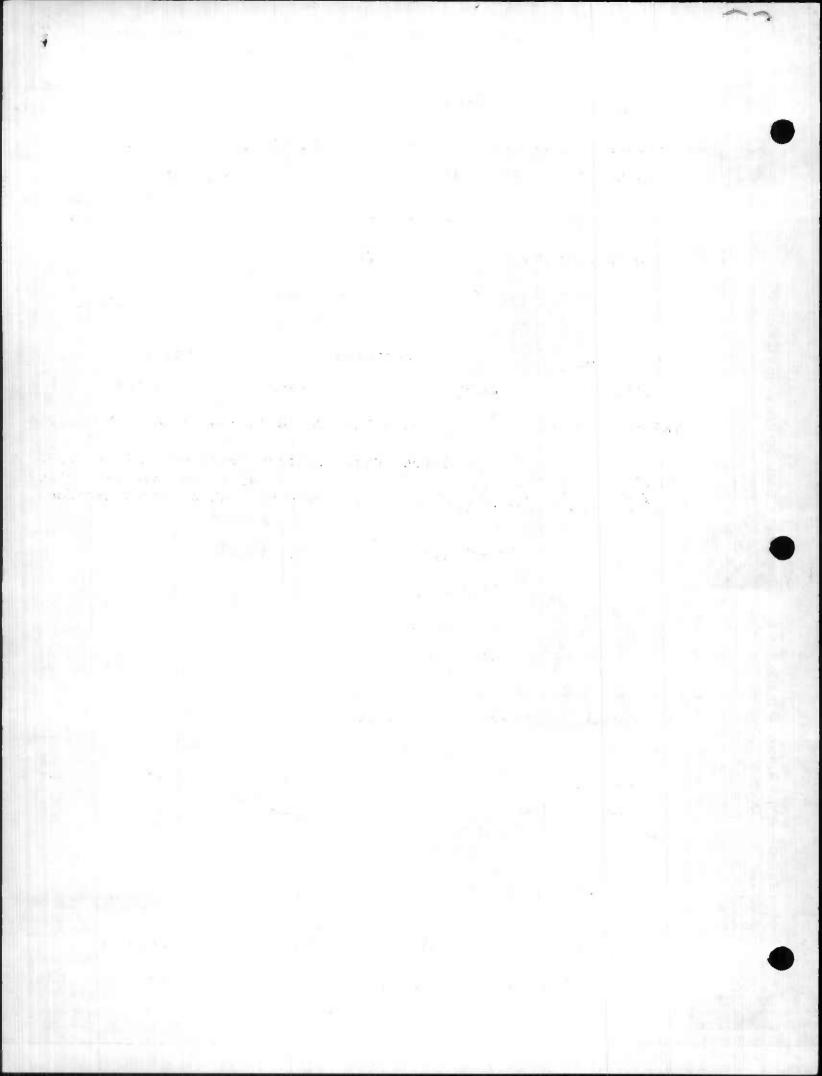
, 821 N. EUTAN ST, fint 308 1+ASI+MI 32 Registrar's Signatura

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29c. License number

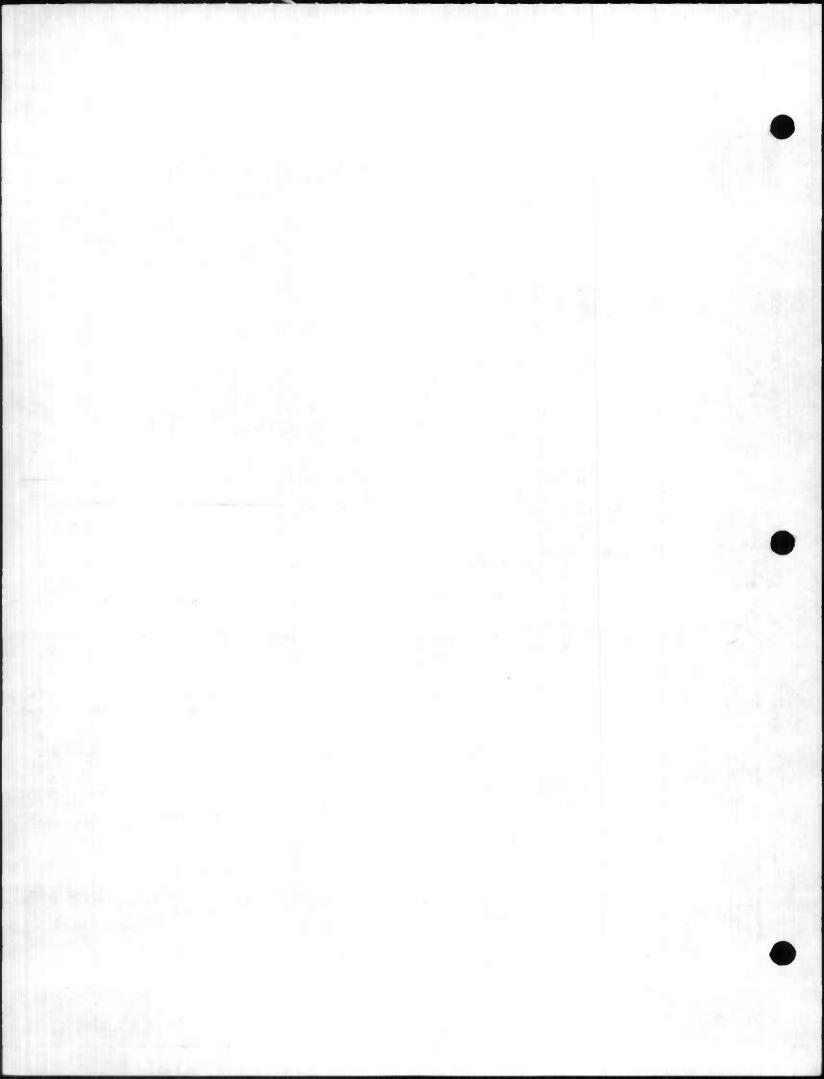
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29d. Data signed (Month, Day, Year)



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/Medical Examiner	4a Facility Nama (If not institution, give			4b. City, Town, or Lo		4c. County		
CAGIIIIICI	4018 Fairfax	Road		Baltimo	re	N	A	
Funeral Director	5. Social Security Number 6. Se 158-24-2240	711 0000	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Y	ear) 1935	9. Birthplaca Country)	(State or Foreign
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With With Did		L Pard	10f. Zip Code	16	100		S.A	
eeth 23	11. Maritai Status	12. Was Decedent Evar in U,S.			ecify Vas or No-		- American Ir	ndian
21215-0020 d within 72 hours after death with the Meryland giene. r than "natural", or forms 23s or 28s-f show the Model Exercise may be notified.	3 □ Widowed 4 □ Divorced	Armed Forcas? 1 □ Yas 2 ☑ No If Yas, Give Year or Datas:	13. Was Decedent of I If Yas, specify Cub		Rican, atc.)		k, Whita, atc. Black	2
yland 21215-0 build be filled within 72 ho Mentel Hygiene. Introduction That Institution and event, the Medical To Be Completed	15. Decedent's Ed	ucation 16a.	Decedent's Usual Occup (Giva kind of work done lifa. DO NOT use retire	pation	16	b. Kind of Bu	sinass/Industr	у
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Baltimore, permit. Pages 1 at Department of Nes Important: if then important: if then any injury or othe once.	21. Signature of Funaral Sarvice Licans	Crops a	22. Nama and Addra	4300 W	altimor ABASH AVENU	e, Ma:	ryland	21215
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Physician	snock, or naart failura. List only o	na causa on aach lina.						rval Between set and Death
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6	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury						1	
Bollow Market	regulting in death) I set	Dua to (or as a co	onsequanca of):					
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ds, P.O. lires that the de signed by the a de be deteched d by Physic d by Physic	Part II. Other significant conditions co	ntributing to death but not rasulting in	tha underlying causa give	ven in Part I.	23b. Did tobs	cco use con	tribute to the	cause of death?
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Division of Vital Records, P.O or Attending Physician: The law requires that the affer death. Director: After this certificate has been signed by the funeral director, page 2 should be deteched by the funeral director, page 2 should be deteched thin by the funeral director.			= 3-10				Odb More o	udana stindina
requirements					24a. Was an a performe	d?	availab	utopsy findings le prior to etion of cause
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Division of the Hospital or Attending Phone at the death. The Funeral Director: After the pletely filled in by the funeral edical Certification:	29a. Cartifiar 1 1 Certifying Phy	sician: To the best of my knowledge,	doath accurred at the time	To date and place	and due to the cour	20/2\ 22d 22		4
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Division of Vital Re To the Mospttal or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29b. Signature and title of cartifier	and manual stated.	29c. Licens	se number	29d	. Data signed	Month, Day,	Year)
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State Registrar	SEP 2 4 1998	Beneva 1	9 1	,				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #26 Per MD Per GP Film G763 9-24-98RC Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Gordon Weitzel 12:04 PM September 18 1998 /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Hospice of Baltimore Gilchrist Baltimore County Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 8, 1925 9. Birthplace (State or rowen, Country) Baltimore, Maryland 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Months Days Hours 219-18-1600 73 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Baltimore County 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ir than "naturel", or items 23s or the Medical Examiner must be r 13 Elmont Avenue 21206 USA Funerai filed within 72 hours after death Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14 Rece - American Indian 11. Maritel Status Bleck, White, etc. 1 ☐ Never Married 2 X Married 1□ Yes 2□No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) WA Self-Employed T. Weitzel & Son 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Herman Tilehman Weitzel Mary Gertrude Dinsmore 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) of Health a item 27 is Doris K. Weitzel (Wife) 13 Elmont Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 1 Buriel 2 Cremation 3 Removal from Stete ö Parkwood Cemetery September 21, 1998 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland injury 22. Name and Address of Facility Lassahn Funeral Home, Inc. 21. Signature of Funerel Service Licensee any ir 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. 7401 Belair Road Baltimore, Maryland 21236-4625 Approximate Interval Between Onset and Deeth Physician Immediate Ceuse (Finel disease or condition resulting In deeth) metastatic lung Cancer /Medical month Examiner Examiner Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting in death) Lest Due to (or as e consequence ot): Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveileble prior to completion of ceuse of death? 24e. Was en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1□ Yes 2No 10 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: 1 Natural 2 □ Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide alte Dire ò 24 hours Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examinar: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier edicai (Check only one) within 2 To the F To the 29d. Date signed (Month, Dey, Year)

Registrar

31 Date filed (Month, Day, Year) SFP 2 4 1998

30. Name and address of person who completed

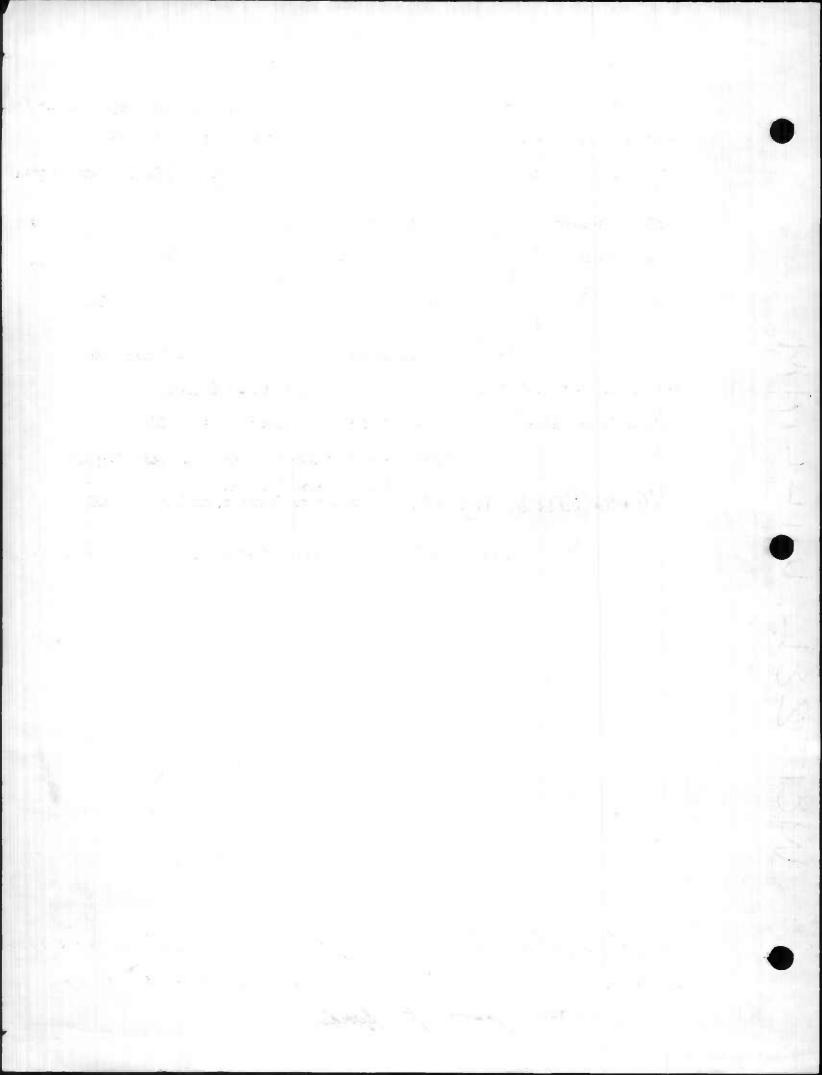
29b. Signature and tifle of oertifie

32. Registrer's Signature

cause of death (them 23a) (Type, Print)

N. Charles

St. Balto. md 21204



Please Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Month Yeer 12:55 am RUSSELL JOSEPH WALDEN 1998 SEPT. 22, 4b. City, Town, or Location of Deeth 4a Facility Name (If not Institution, give street and number) 4c. County of Death 4707 Park Heights Avenue (res.) Baltimore 8. Date of Birth (Month, Day, Year) 03/12/1927 if Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 □ F 212-22-1427 71 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 4707 Park Heights Avenue 21215 U.S.A. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Home Elemantary/Secondary (0-12) Collage (1-4or 5+) Entrepreneur 12th 2+ Improvement 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Walden Lillie Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilsey L. Barksdale 4707 Park Heights Ave., Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 9 / 28 / 9 8 Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Garrison Forest Vet. Cem. Owings Mills, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 complications that cause only ona cause on master Do not enter the mode of dying, such es cardiac or respiretory errest, Approximate Interval Batween Onset and Death ter the diseas haart failure. two Immediate Cause (Final disease or condition resulting in death) enocarcinoma months Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 1 Yae 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2) No 26. Place of Daath (Check only one)

Physician /Medical Examiner law requires that the death certificate be executed

Physician

/Medical

Examiner

MD

Funeral

Director

"natural", or items 23a or 28a-f show solds! Examiner must be notived at

pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Menial Hygiene. Important: If Item 27 is merked other than "natural", or thems 23a any Injury or other traumatic event, the Media

altimore, Maryland 21215-0020

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Funeral

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Completed

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Examiner physician end the buriel-transit Physician/Medical signed by the e þ Completed is certificate has director, page 2 Be Certification: To

funerai death.

Division of Vital Records, P.O. Box 68760,

Attending Physician:

rector

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Medical

25. Was casa refarred to medicel examiner? No 1 Yes 2 27. Manner of Death

1 Natural 2 Accident 5 Panding investigation 3 Suicide 4 Homicide

6 Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28a. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the bast of my knowledga, death occurred at the tima, data and place, and due to the causa(s) and mannar as stated.

Medical Examinar: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number

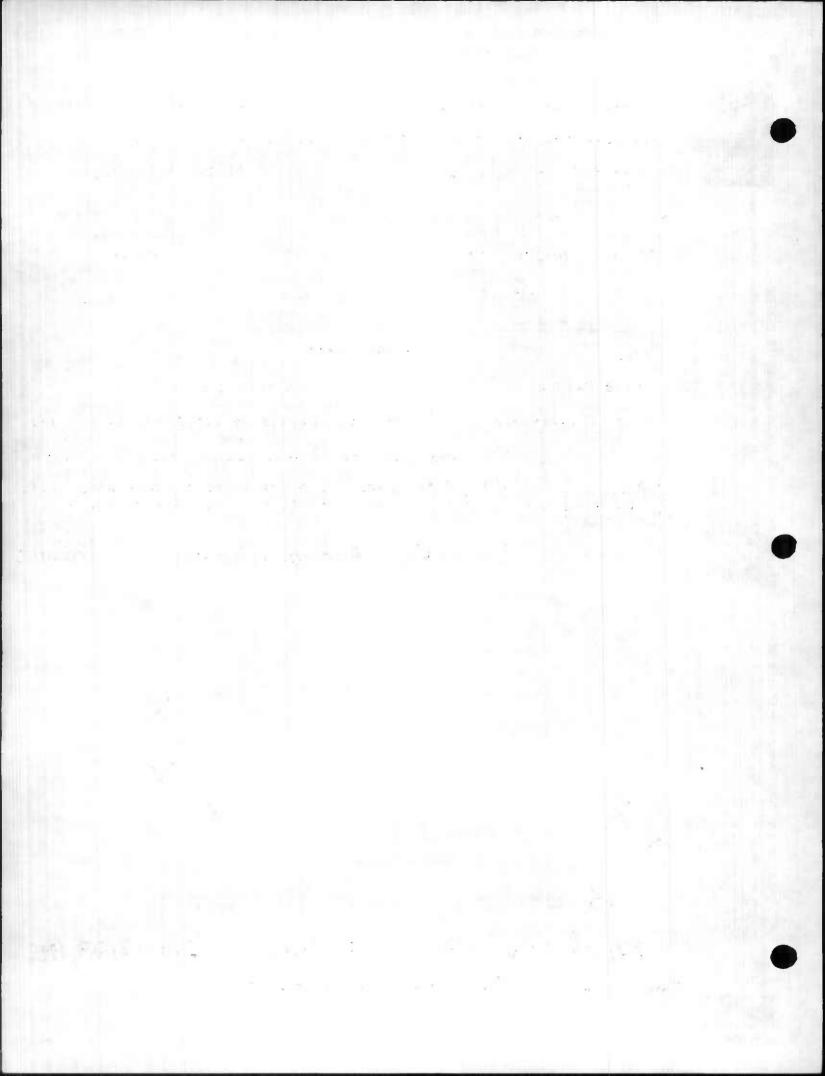
29b. Signature and title of corple

29d. Date signed (Month, Day, Year)

of person who completed ceusa of death (item 23a) (Type, Print) Hospital

Sinai \$2. Registrar's Signature

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

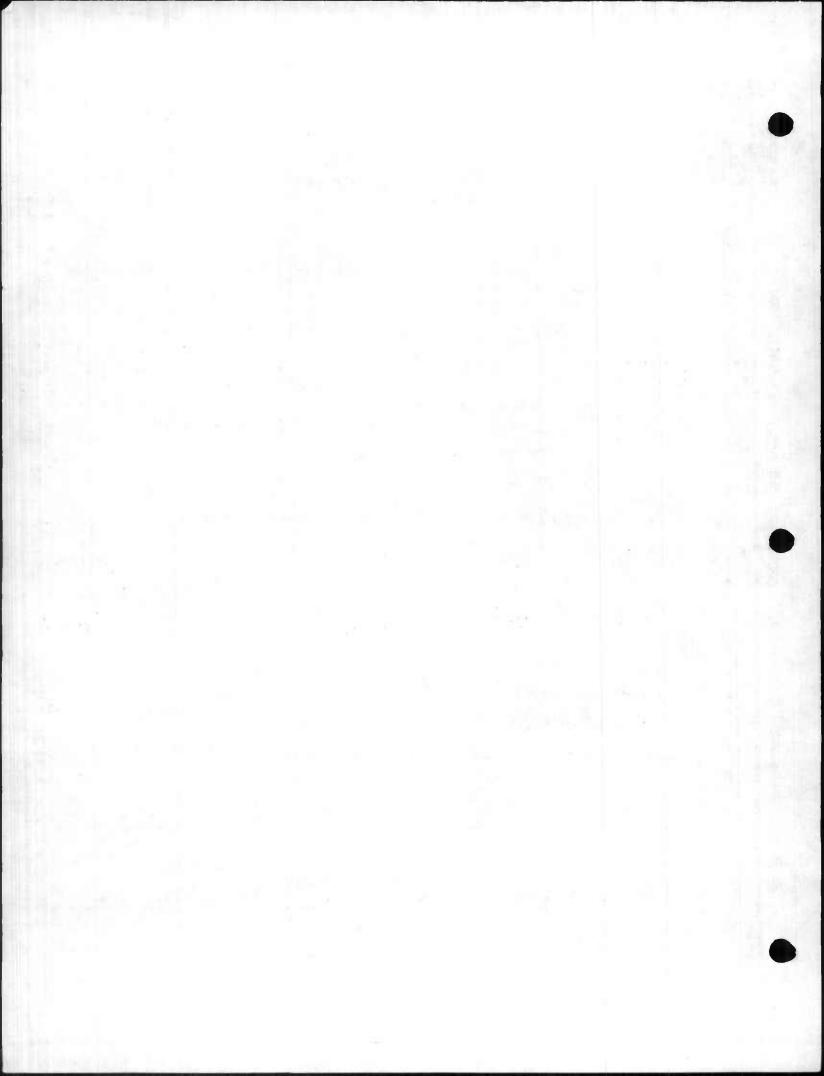
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month **Physician** Richard White 10:15a.m. Sept. 15, 1998 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4700 Homesdale Avenue Baltimore If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 15 4 20 F 227-03-6135 81 Director Sept. 8, 1917 Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Md. n/a Baltimore Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3034 Windsor Avenue 21216 USA "natural", or items 23a 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Merital Status Black, Whita, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Nerried Baltimore, Maryland 21215-0020 1 Yes 2 Ne Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Phygiens. other then 'n **GSA** Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahould be filed with Department of Health and Mental Hygiens Important: if them 27 is marked other the any Injury or other traumatic event, the 1006. Fort Meade, Md. Electrician Helper 8th Grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne) Be Frank White Margaret Scott 19a. Informent's Name/Reletionship (Type, Print) daughter/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Chineta Alford/Alvin White son 804 Tiffany Trail Abingdon, Md. 21009 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Durial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) Sept. 21 Randallstown, Md. King Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final ardiomyopA the disease or condition resulting in death) Examiner Due to (of as a consequence of) Examiner DERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last and Due to (or es a consequence of): physician a Box 68760 Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Vinknown of the prostate þ 24b. Were autopsy tindings available prior to completion of cause of death? Obstructive PulmonARY Disease 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No certificate Division of Vital Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Mother (Specify) RESIDENCE 1 Yes 2 No Certification: To this After this 28a. Dete of tnjury (Month, Day Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) a Funeral Direct 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 29e. Certifier edical To the Hosp within 24 ho To the Fund completely f (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year))2203 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltimore, MO. Larry S. Perry 2116 Maryland 31. Date filed (Month, Day, Year) SEP 2 4 1998 32. Registrar's Signeture

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🔾 📮 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month :30 9 **Physician** Thelma Mae Ashley September 5, 1998 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 100 Mercury Court Residence: Havre de Grace Harford | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Aga (in yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2/3/F Yrs. 217-26-4879 Director 68 Maryland Usual Rasidanca of Dacadant the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at 1 Yas 2 No Maryland Harford 100 Mercury Court Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A. 100 Mercury Court 21078 Funerai 72 hours after deeth 14. Race - American Indian, Black, White, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Yas ② No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 X No Specify: Specify: à White ¾XWidowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Dacedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Aberdeen Proving Ground of filed within 7 of Hygiene. College (1-4or 5+) One Year Elamentary/Secondary (0-12) Human Engineering Lab Aberdeen, Maryland permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if them 27 te marked othe any Injury or other treumatic event other traumatic event, 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Floyd Calvert Thelma R. McKinney 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Richard N. Ashley (son) 625 Valley Lane, Towson, Maryland 20b. Piaca of Disposition (Nama of cematary, crematory or other placa) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 9/10/98 Aberdeen, Maryland 21. Signatura of Funarai Sarvice Liga 22. Nama and Addrass of Facility Lee A. Patterson & Son Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Perryville, Maryland 21903-0188 Approximata Interval Batw Onsat and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) ACUTE ANTERIOR MYOCARPIAL INFARCTION /Medical 1 DAY Examiner Dua to (or as a consequence of): buriel-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Lest pue Dua to (or as a consequence of) physician s the buriel Physician/Medical Dua to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t HYPERTENSION 1 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen hes 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No certificata Attending Physician: Be 25. Was case refarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☒ Rasidance 6 ☐ Other (Specify) Certification: To 1 Yas 2 No this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fund 5 Panding 1 Yas 2 No invastigation 2 Accidant 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifian Medical 29b. Signatura and titia of cartifiar 29c, Licansa number 29d. Data signed (Month, Day, Year) D08096 Andew Nowshould not 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

ANDREW NOWAKOWSKI MD 125 NI MAIN ST. BEZ ATR, MID 2014 10

State Registrar 31. Data filed (Month, Day, Year) SEP 1 0 1998

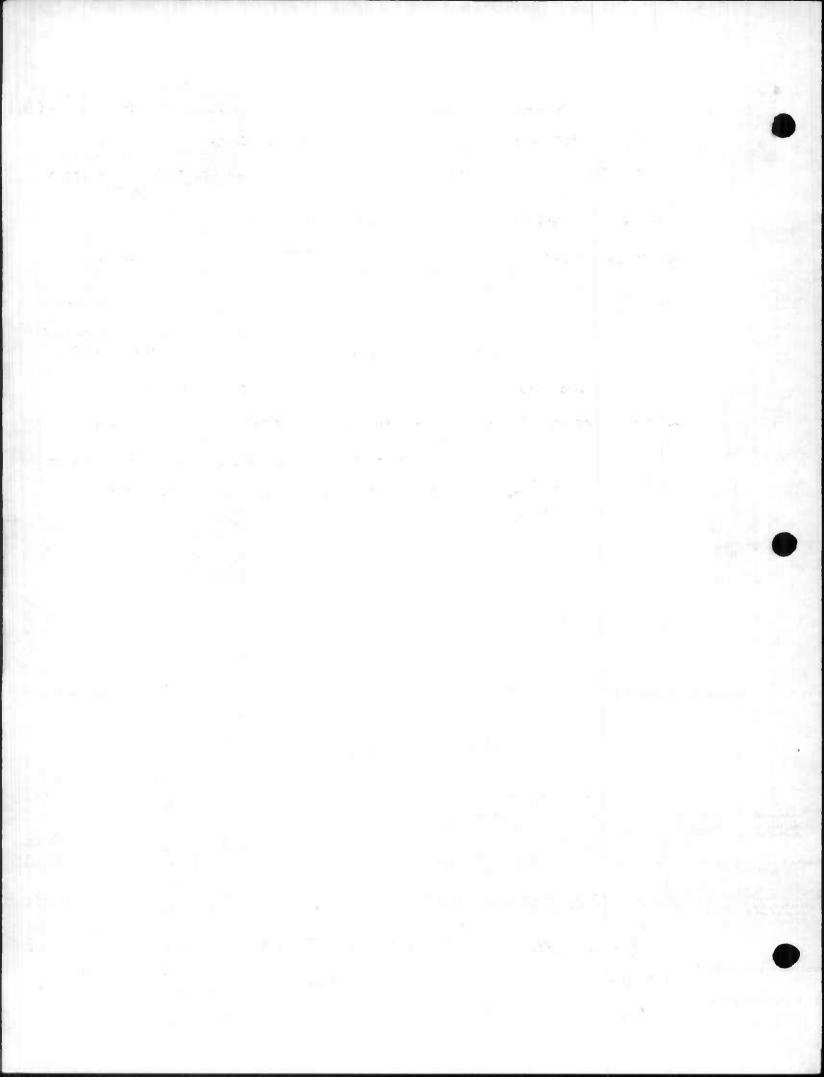
32. Registrar's Signature 9. Sports

Baitimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vitai Records.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 12, 9/9/98 ban Ceis Co. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Joseph В. Anderson September 06, 1998 10:17PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Perry Point
| H Undar 1 Yaar | H Undar 24 Hrs. | 8. Da VA Maryland Health Care System Cecil 8. Data of Birth (Month, Day, Year) NOV 29, 19 6. Sax 1(X) M 2□ F 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Hours 205-26-8093 64 Yrs. 1933 Pennsylvania **Director** Usual Rasidanca of Dacadant filed within 72 hours after death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Llmits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Cecil Conowingo 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 2 Hillcrest Road 21918 USA Funeral 12. Was Dacadant Evar in U,S. Armad Forces? 1 Pas Who If Yas, Give 1953 - 1973 Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian Btack, Whita, atc. 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorcad White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Dacadant's Education (Spacify only highast grada complated) Elementery/Secondery (0-12) College (1-4or 5+) Hygiane. 12 Postal Worker U. S. Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Surnama) Be Pegas 1 and 2 should be 1 nent of Haalth and Mantal I Orville T. Anderson Lillian Richards 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) tother tr 2 Hillcrest Rd., Conowingo MD 21918 Erika E. Anderson/Wife 20b. Place of Disposition (Nama of Cramatory, cramatory, or other place)
Notice of Disposition (Nama of Cramatory, or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition permit. Pegas
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 9-10-98 Nottingham, PA Baptist Cemetery
22. Nama and Address of Facility
R. T. Foard Funeral Home, P. A.
111 S. Queen St., Rising Sun, MD 21911 21. Signature of Functal Service Licensee Dum uchard and the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, line. Approximata tntarvai Batwean Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting daath) /Medical unknown Sepsis Examiner Dua to (or as a consequence of): Examiner sician and buriel-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Ceuse (Diseesa or Injury that initiated events rasulting in death) Last Due to (or as e consaguança of): physician s the buries P.O. Box 68760, Physician/Medical Due to (or as a consaquanca of): 80 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Peripheral vascular disease, Dementia Records, þ ata hes been signe paga 2 should be Wera autopsy findings available prior to Completed 24a. Was an autopsy parformad? complation of causa of death? 1 Yas 2 XNo 1 Yas 2 No cartificata Division of Vital Hospital or Attanding Physician: Be 25. Was casa rafarrad to medical 26. Pteca of Daath (Check only ona) Other: 4 Nurstng Home 5 Residence 6 Other (Specify) 1 Yas 2X No Certification: To 1 X tnpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred Aftar 1 Natural 2 Accidant 5 Panding invastigation 1 ☐ Yas 2 ☐ No deeth. ours after deeth. Annual Director: A filled in by the fo 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Ptece of Injury - At homa, ferm, straat, factory, offica building, atc. (Spacify) 4 Homicida To the Hospital of within 24 hours at To the Funeral D completely filled 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and mennar as steted.

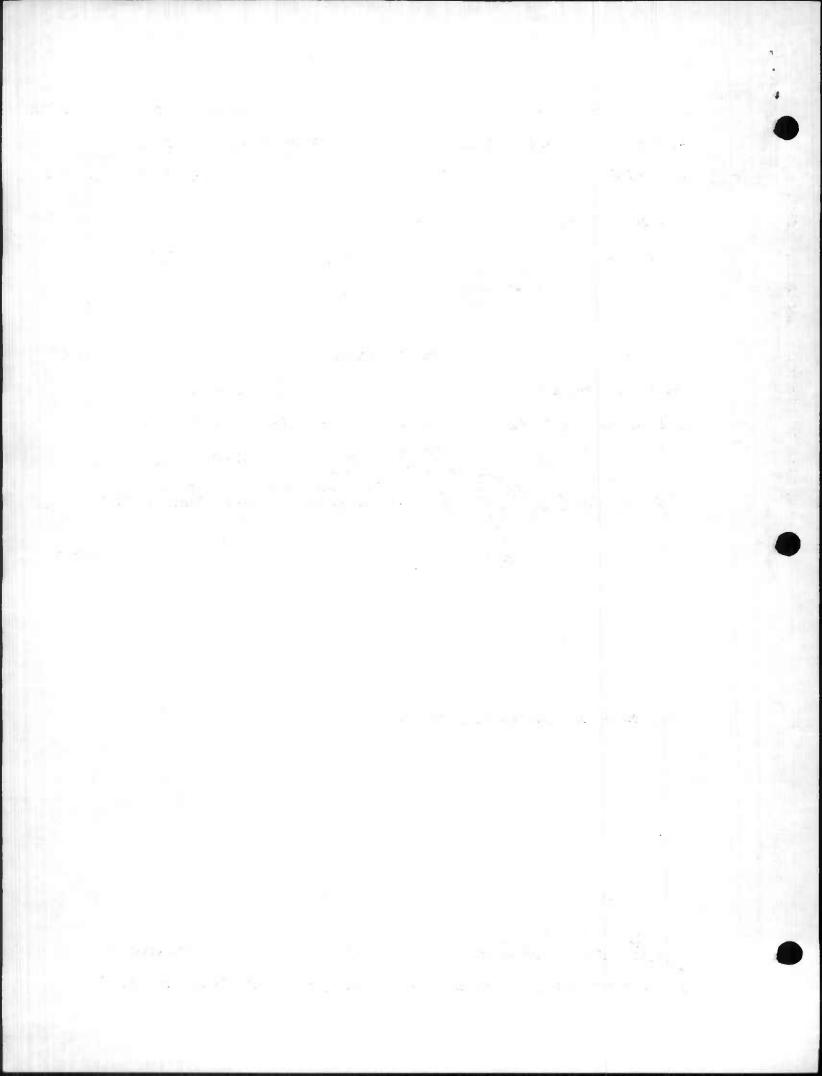
2 Medical Examiner: On the basis of examination end/or invastigetion, in my opinion, death occurred et the time, dete and place, end due to the cause(s) and mennar stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Date signad (Month, Day, Year) September 7, 1998 D28535 ame end eddrass of person who complated causa of death (Itam 23a) (Type, Print)

12

KNOWN TO PHYSICIAN: ANDERSON, JOSEPH

State Registrar 31. Data filed (Month, Day, Year) SEP 0 9 1998

SALLIE RIXEY, M.D., VA Maryland Health Care System, Perry Point, MD 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of D	leath Reg. No. 29283
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
/Medical	Edna Austin 4s Facility Name (If not institution, give street and number) 4b	09 01 98 9:45 PM City, Town, or Location of Death 4c. County of Death
Examiner	Prince George's Hospital Center	Cheverly Prince George's
Funeral		W Under 24 Hrs. R Date of Birth 9 Birthology (State or Foreign
Funeral Director	213-53-7457 1 M Mark 60 Yrs. Months Days Usual Residence of Decedent	Hours Min. (Month, Day, Year) March 10, 1938 Jamaica, W.I.
puel se m	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
death with the Menyland ims 23s or 28s-f show crimat be notified at	N/A N/A St. Thomas, Wes	t Indies XX 2 No
vith the Me	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
23a 23a	Pamphret District Yallahs	N/A Jamaica, W.I.
020 uns efter aff, or the	Armed Forces? If Yes, specify Cuban,	panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. Specify: Black
within 72 ho	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unk 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Domestic Work	
and 2 be filed that Hygin dother event, the		8. Mother's Name (First, Middle, Maiden Sumame)
aryland should be filed and Mental Hygi marked other umatic event.	Roland Leslie	Adina Austin
Maryland d 2 should be flie th end Mental Hy 7 le marked other traumatic event		d Number or Rural Route Number, City or Town, State, Zip Code)
1 and 1 and 1 the ith		enue, Landover, Maryland 20785
Baltimore, pemil. Peges 1 at Department of He important: if item eny injury or othe	20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Morant Bay Cemeter	
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each fine. Immediate Cause (Finel disease or condition resulting in death) Due to (or es a consequence of):	Onset and Deeth
6876(liceta be physicia the bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
a dear	Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given	in Pert I. 23b. Did tobacco use contribute to the cause of death?
O # 50 P	CORONARY ARTERY DISEAS	1 Yes 2 No 3 Probably 4 Unknown
BCOrd aw requir ts been s 2 should		24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death?
- F & a O		1127 Yes 2□No 1□Yes 222 No
Of Vital I Physician: The this certificate ral director, par : To Be Co	axaminer/ Hospitel: Other	26. Place of Death (Check only one)
- 2 00	27. Manner of Death 28a. Date of Injury 11⊠Natural 5 Pending (Month, Day Year) 28b. Time of 28c. Injury Work?	4 Nursing Home 5 Hesidence 6 Other (Specify)
D 9455	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
the Hospital hin 24 hours the Funeral mplately filled	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	, date end place, and due to the cause(s) end menner as stated nion, death occurred at the time, date end place, end due to the cause(s)
To the composition of the compos	29b. Signature and title of certifier 29c. License is	number 29d. Date signed (Month, Dey, Year)
	1 () () HE	55 79 September 5, 1998
(4)	30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)	
	Bank-Ugoala, M.D. 1160 Varnum Street, N.E.	Washington DC
State Registrar	31. Date filed (Month, Day, Year) SEP 0 9 1998	

SEP 3 3 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedant's Nama (F	iret Middle 1 ees	1	- (Certificate	or Death	2. Date of Dea	Reg. No.		3. Time of Death				
Physic	ian	James Wi						Month	Day	Year					
/Medi Exami		4a. Facility Name (If no					4b. City, Town, or	Sept.		of Death	1:40 am				
LAGIIII	1161	CIVISTA	MEDICA	L CENTER			LAPLA	ТА	(CHARL	.ES				
Funeral Director		5. Social Security Number 213-16-29	er 6. Se		e (In yrs. last birtho	Months D	ear If Under 24 Hrs ays Hours NOV		3,1917	9 Birtho	lace (State or Foreign				
anyland show id.at	10	1.00	b. County		10c. City, Town o					1	0d. Inside City Limits				
the M 28a-f sottfle	ecto	MD Charles La Plata 106. Street and Number 107. Zip Code							40- ON	2					
ath with 23a or wat be a	Funeral Director	9555 Gre				206	46		10g. Citizen of V USA						
15-0020 72 hours after death with the Marylar "naturel", or thems 23e or 28e-f show relical Examiner must be notified at	by	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent I Agmed Forces? YE Yes 2 N If Yes, Give Year or Dates:	1943 1945	13. Was Deceden If Yes, specify 1 Yes 2		14. Race - American Indian, Black, White, etc. Specify: White							
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Mental Hygiene. 7 is marked other than "naturel", or traurretic event, the Medical Exam	Completed	15. (Spacify of Elamantary/Seconda	Decedant's Edu only highast grad ry (0-12)	cation e <i>completed)</i> College (1-4or 5	(C)	ecedent's Usual C Give kind of work of fa. DO NOT use r oiler E1	ona during most of wo stired)	orking	16b. Kind of Bu		nment				
Hyge Hyge Hyge Hyge Hyge		17. Father's Nama (Firs	t. Middie, Last)		ЪС	me (First Middle			iment						
ylan Mental Mental Mental	To Be	James Wis		man				18. Mother's Name (First, Middle, Maiden Surnama) Grace Smith Boarman							
5 70 90 %		19a. Informant's Name. James Boa:	9a. Informant's Name/Ralationship (Type, Print) ames Boarman III/Son 19b. Mailing Address (Street and Number or Rura 9540 Wise Lane La P								Coda)				
Saltimore, semit. Pages 1 a Appartment of Has reportant: If Nem my injury or othe my injury or othe MSE.		20a. Mathod of Disposition 1 Deposition 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State cemetery, crematory or other place) 21 Date 20c. Location - City or Town, State cemetery, Crematory or other place) 22 Date 20c. Location - City or Town, State cemetery, Crematory or other place) 23 Date 20c. Location - City or Town, State cemetery, Crematory or other place)													
Departs Departs Imports any inju		21. Signature of Funera	al Service Licens	000	m00817	AREHAR'	ddrass of Facility C-ECHOLS OX 567 LA								
Confidence be associated by Medical Examination by Stock and Confidence of the Confi	vMedical Examiner	23a. Pan1. Enter the dishock, or heart fall immediate Cause (Final disease or condition resulting in death) Sequentially list condition fany, leading to immediate Cause. Enter Underlyin Cause. (Disease or Injuit that initiated evants resulting in death) Last	ons, diate g	Chro		requence of):	shocytic carcin	L Le	okowi s	2 F	Interval Batween Onset and Death Lew Woulty Lawy Teasy Lew 7-291				
death cert	Iciar	Part II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part I.							23b. Did tobacco use contribute to the cause of death?						
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VICAL The decision of the continuate inector, peg	Be	25. Was casa rafarred to examiner?		lospital:			Other	eath (Check only o							
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completaly filled in by the funeral director,	ation: To	1 Yas 2 No 27. Manner of Death 1 Natural 5 2 Accident	☐ Pending Investigation	28a. Date of Injui (Month, Day	y 28b. Tim	atient 3 DOA na of 28c.	Other: 4 Nursing Injury at Work? 1 Yes 2 No	Home 5 Resid	lence 6 Oth		у)				
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	Certification:	3 Suicide 6 4 Homicida	fica	28f. Location (5 City or Tox	Street and Numb m, State)	er or Rura	i Route Number,								
e Hospit 124 hour Funera letaly fille	edical (29a. Certifier 1 (Check only one)	Certifying Phys Medical Examin	sicien: To the best of ner: On the basis of and manner sta	examination and/o	leath occurred at to or investigation, in	na time, data and plac my opinion, daath occ	a, and due to tha curred at tha tima,	cause(s) and ma data and place,	nner as s	lated. tha ceuse(s)				
To th To th comp	Me	29b. Signature and titla	of certifier			29c. L	canse number		29d. Date signer	(Month,	Day, Year)				
		10		· O. /L	- M	D	D-21173		9/1	3/	76				
		30. Nama and address Niran P. Si					Suite 104	Waldor	f, MD	20603	}				
Ct	ate	31. Date filed (Month, D			r's Signature	4. do									



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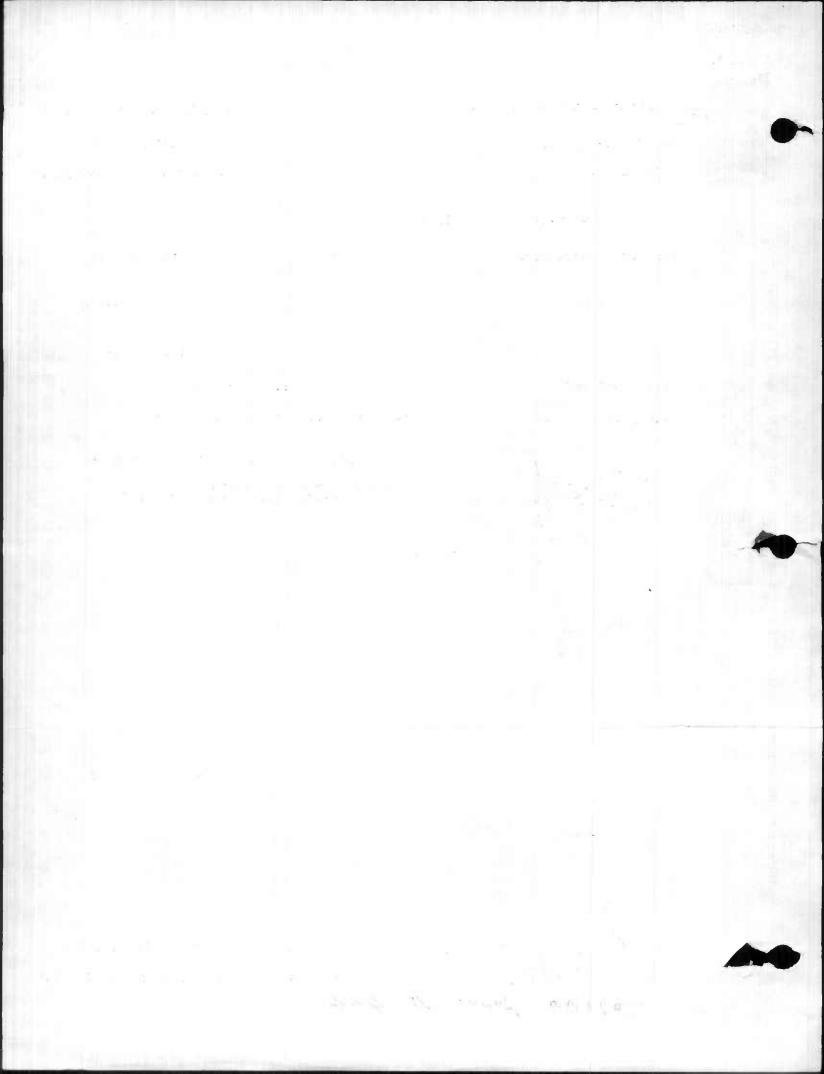
State of Maryland / Department of Health and Mental Hygiene 98 29285

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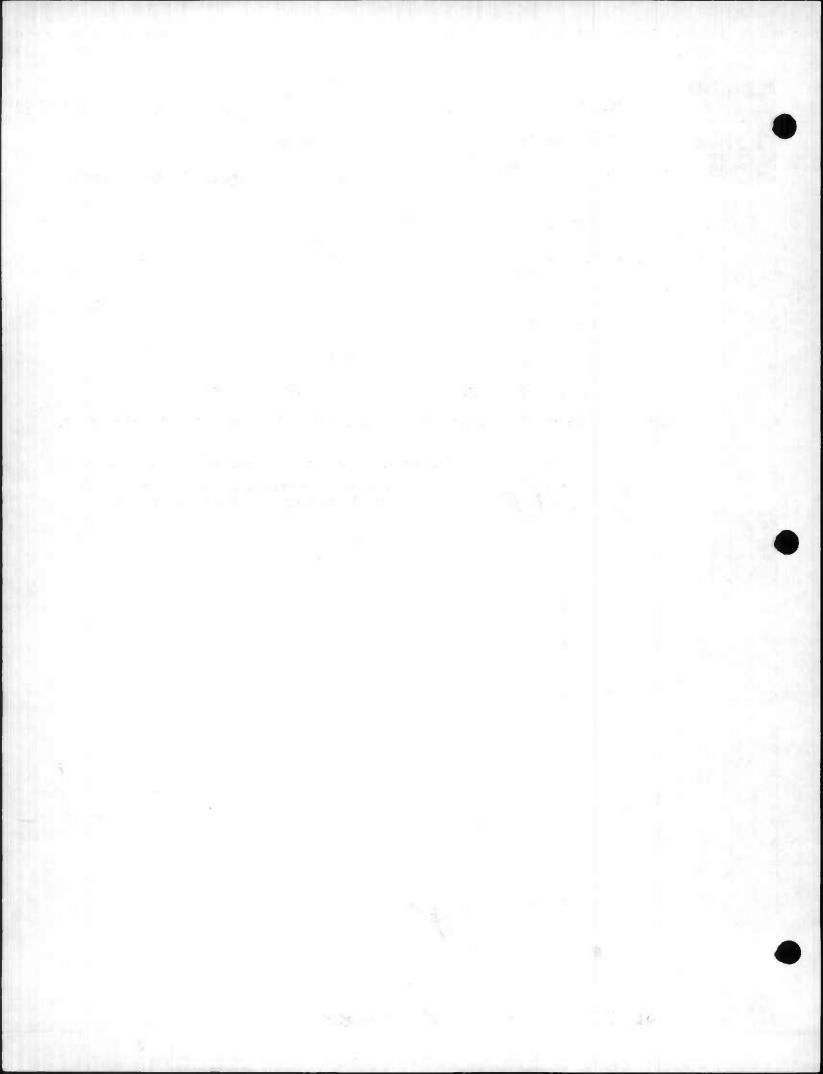
			State of Maryland		nt of Health and te of Death	Mental Hygie		29287
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lan	2 should and Men is marke sumatic	19a. Informant's Name/Ralationship (T)	rpe, Print)	19b. Mailing Addras	s (Street and Number or F	Rural Routa Number, C	ity or Town, Stata,	Zip Coda)
	r Health tem 27 other tr	Robert C. Bounelis				Glen Burni		21061
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tir		4 Donation 5 Other (Specify)			s Cemetery	9-10-98 An	napolis,	Md.
Ba	permit. Pe Departmen Important any Injury pnce.	21. Signatura of Funaral Sarvice Licens	Powell		nd Addrass of Facility Jo ke of Glouce			al Home, Inc. s,Md. 21401
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	Physician /Medical Examiner	Immediata Causa (Final diseasa or condition rasulting in death)	Cavolio ge	nic sh	XK			3 days.
8760,	by solidar and the burial-fransit dical Examiner	Sequantially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Diseasa or Injury that initiated events	Dua to (or Atheros C	ischem as a consequence of louotic L	ic cardion	wyopathu	1	10 years
Box 687	nding p use as	rasulting in death) Last	Dua to (or a	as a consequence of)				
0	the deal by the at sched for hysical	Part II. Other significant conditions con	ntributing to death but not rasul	ting in tha undarlying	causa given in Part I.	23b. Dld tobs	icco use contribut	to the cause of death?
۵.	es that igned b be dete	End Stage rend	al disease			1 🗆 Yes	2□ No 3년 P	robably 4 Unknown
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<u> </u>	ysician: The is certificate director, pag	25. Was casa rafarred to medical examinar?	lospital:		26. Placa of De	eath (Check only ona)		
lon of Vital	Plant P	1 Yas 2 No 27. Manner of Death Natural 5 Panding 2 Accident Invastigation	1/2 Inpatient 2UE	R/Outpatient 3 D 28b. Tima of Injury	OA 4 Nursing 28c. Injury at Work? 1 Yas 2 No	Homa 5 ☐ Rasidano 28d. Describe how		ecity)
Division	herd lined n by	3 Suicida 6 Could not be datarmined	28a. Place of Injury - At hor building, atc. (Specify)	na, farm, street, facto	ry, office	28f. Location (Stree City or Town, S	et and Number or R Stata)	lural Routa Number,
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	To the To the Comp	29b. Signatura and titla of certifiar	TOTAL FILE	29	c. License number	29d	. Data signed (Mon	th, Day, Year)
		Bartara L. B	Pan M.D.	7	39497	Se	plember	7th 1998
		30. Nama and addrass of person who co	empleted causa of death (Item:	23a) (Type, Print)	110-	7 1		
	State	Bean Bean Bean Data filed (Month, Day, Year) SFP (1) 8 1	Sule 300	400 Be	stgate Koo	d Annap	iolis Ma	d. 21401
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State of Maryland / Department of Health and Mental Hygiene

					Cei	rtificate of	Death		R	leg. No.	S	1200	
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uneral irector		5. Sociel Security Number 6. S 214-54-5855 Usuel Residence of Decedent	ex 7. Age	(In yrs. last	birthdey) Yrs.	If Under 1 Year Months Deys		Min. (M	te of Birth onth, Dey t. 1	Yeer) 2, 1946		ece (Stete or Forei try) ryland	
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or 28	Director	10e. Street end Number				10f. Zlp Code			1	log. Citizen of V	Vhet Coun	try?	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 5, 1998 **Physician** Donald 1018 Ray Baker /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 8. Date of Birth (Month, Dev. Year)
Mar. 21,1926 West Virginia If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Hours Months M 2DF 72 Director 235-32-2532 Usual Residence of Decedent the Maryland works ! 10a. State 10b. County 10c. City, Town or Location t0d. Inside City Limits 14 Ves 2 □ No Maryland Harford Aberdeen Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8 430 Lorraine Street 234 21001 U.S.A. Funeral Reme 2 12. Was Decedent Evar in U,S. Armed Forces?

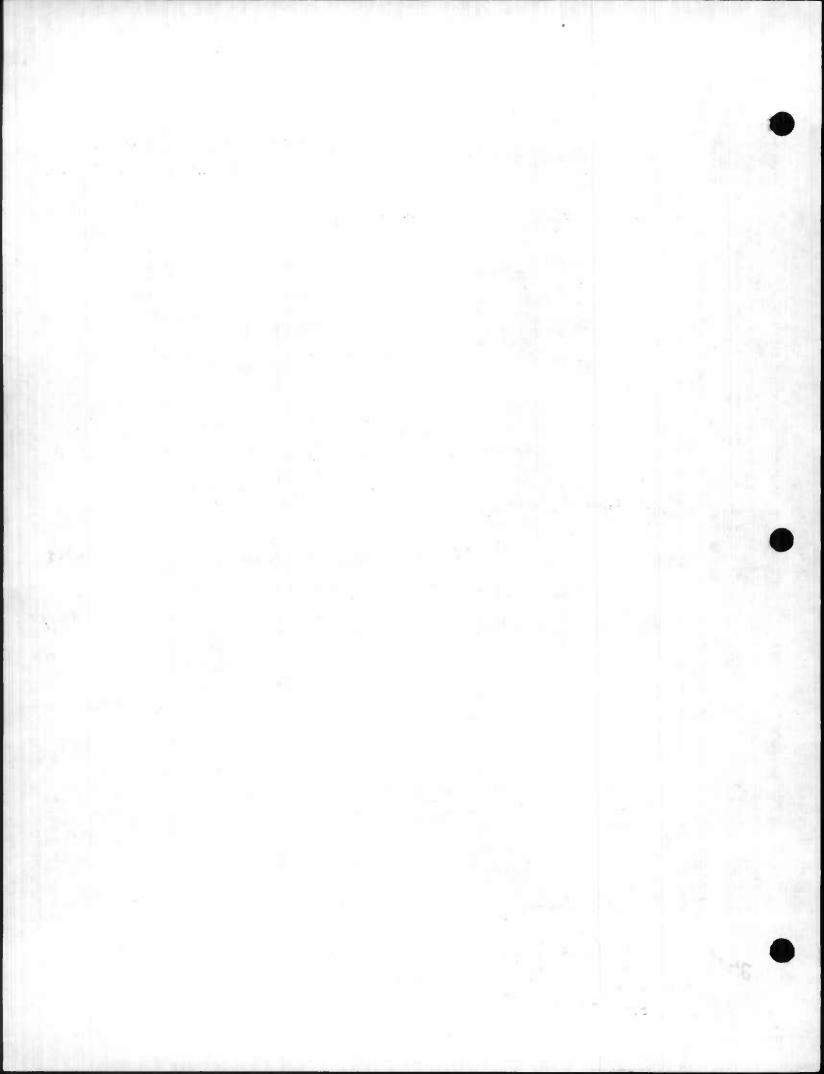
¹♥☑∜es 2 □ No
If Yas, Give
Year or Dates: ₩₩ II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Nevar Married 2 Married 21215-0020 *natural', or 1 Yes 28 No Specify: Specify: p 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest greda completed) 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filled within ment of Health end Mentel Hygiene. mit if item 27 le marked other then ' ary or other traumatic event, ma Ma Elementary/Secondery (0-12) College (1-4or 5+) Sales person 12 Retail Sales Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Milton Baker Effie Tabor 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) vitem: If Item 27 is now, or other Keith D. Baker (Son) 3544 McShane Way, Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Ramoval from State Harford Memorial Gardens 9/8/98 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furteral Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Aberdeen, Maryland 21001–33

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner pue Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medicai 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 3 Probably 4 Unknown 1 Yes 2 No Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 2 UNO 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 NO Certification: To 1 ☐ Inpatient 2 SOER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? After Division 1 Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after e 4 Homicide 6 Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certain 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHAPLES ECK TU 219W · (3)ELHU AUF. ABELLOEUN, MD

Registrar **DHMH 16 Rev 6/95**

State

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State of Maryland / Department of Health and Mental Hygiene [18] Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death September 90 1998 Year **Physician** William Nicholas Baumgartner 2 20 PM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Solomons Nursing Center Solomons If Under 24 Hrs. 8. Date of Birth (Month, Dey, Oct 3 If Under 1 Yaer Months Deys 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foreign Country) **Funeral** 1 N/ 2 F Director 1925 Tennesse 579 22 8088 72 Usual Rasidence of Decedent filed within 72 hours after death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland Calvert Solomons 1 ☐ Yes 2X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country?
United States 13325 Dowell Road 20688 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No If Yas, Giva Yeer or Detas: WWII 11. Maritei Status Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Bleck, White, atc. 1 ☐ Nevar Married 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 18b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. Postal Worker U S Government pemit. Pages 1 and 2 should be filed v
Department of Health end Mentel Hygie.
Important: If Item 27 is marked other ti
eny Injury or other traumatic event, this 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Melden Sumama) Edythe Phillip A. Baumgartner Cordell 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) James M. Madara- son in law 4407 South Shore Dr. Prince Frederick MD 20b. Pleca of Disposition (Neme of cemetary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Data Metropolitan Funeral Service Alexandria Virginia 1 ☐ Burial 2 XCremetion 3 ☐ Ramoval from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funerei Service Licensee 4405 Broomes Is. Rd. Port Republic MD 2067 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haert fellure. List only one ceuse on each line. Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Finei disease or condition resulting in death) /Medical aspiration unk Examiner Due to (or es a consequence-P Examiner requires that the death certificate be executed physician and s the buriel-trans Sequentielly list conditions, it eny, leading to immadiate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): 88 for use es ed by the deteched Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? Mass Rt lung 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown signed t à 24b. Were autopsy findings available prior to completion of causa of death? 24e. Wes an autopsy performed? Completed peen hes 1 ☐ Yes 2 No 1 Yes 2 No director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: ► Netural 5 Pending investigetion 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide ŏ • Funeral Hospital To the Hosp within 24 hou To the Fune completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signeture end little of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Sept 11, 1998 D27180 EUM mouro 30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print) Zahir Yousaf, 2417 Solomons Is. Rd. N. Huntingtown MD 20639 M.D.

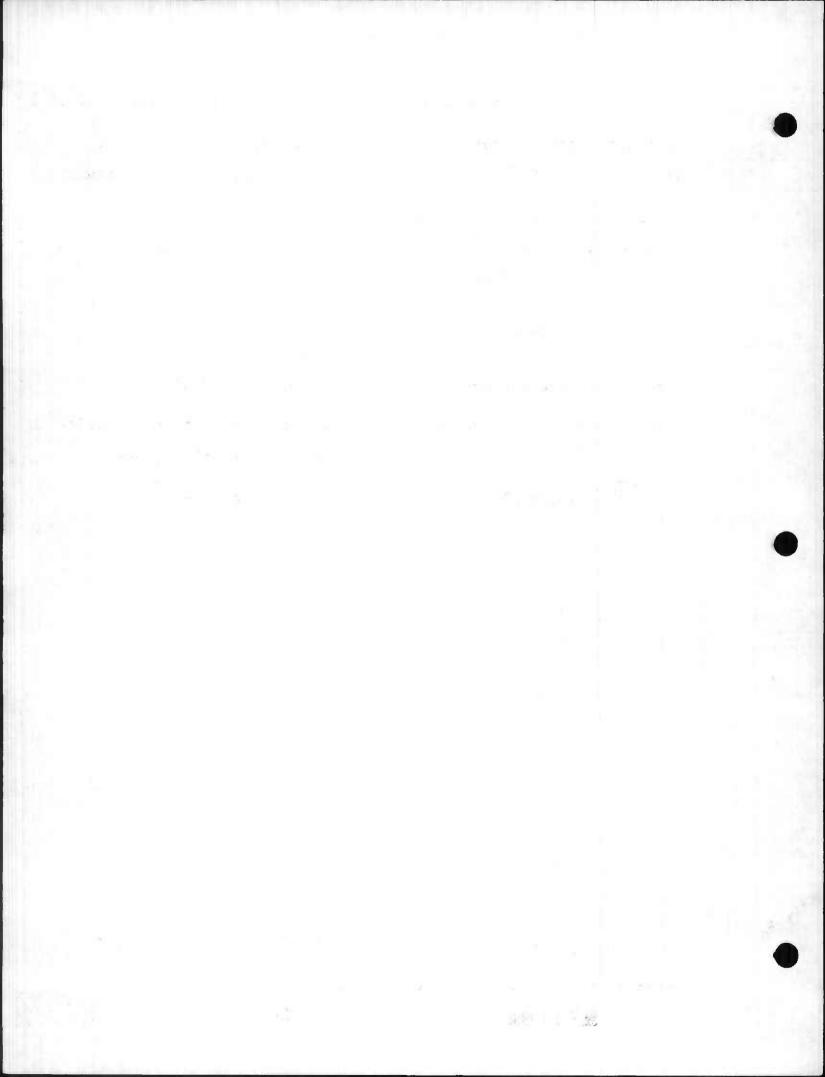
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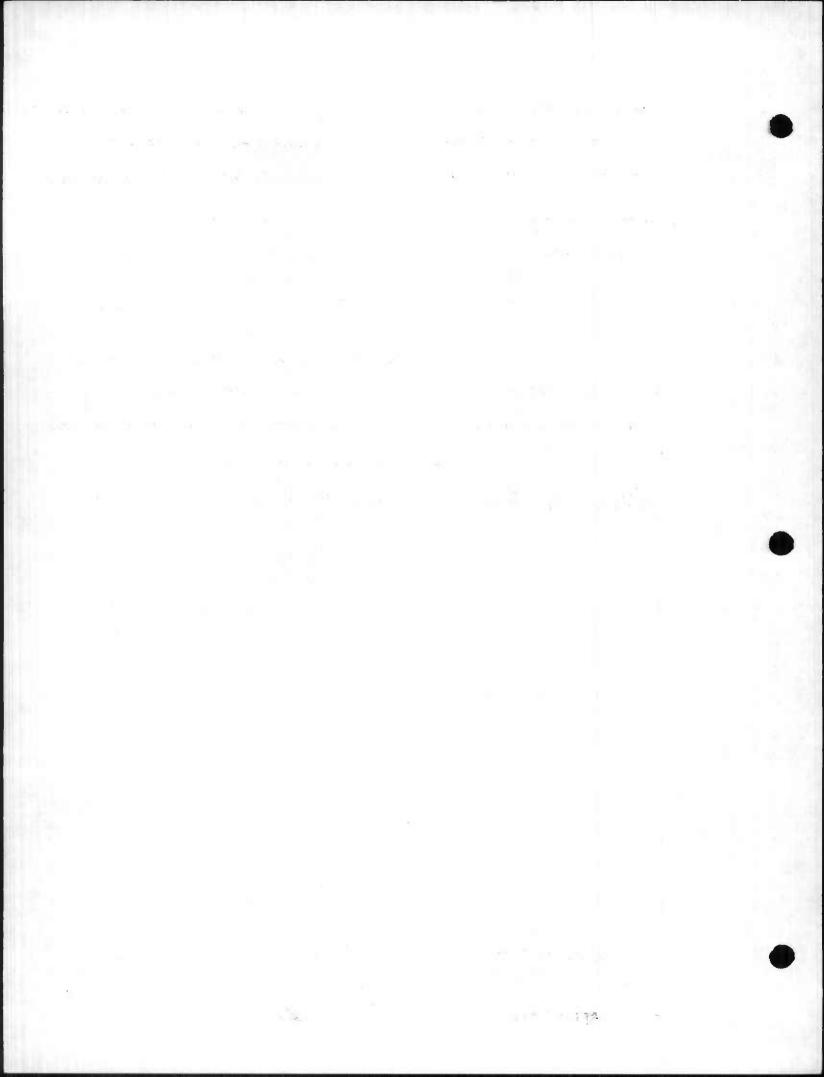
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Division of Vital Records. P.O. Box 68760.

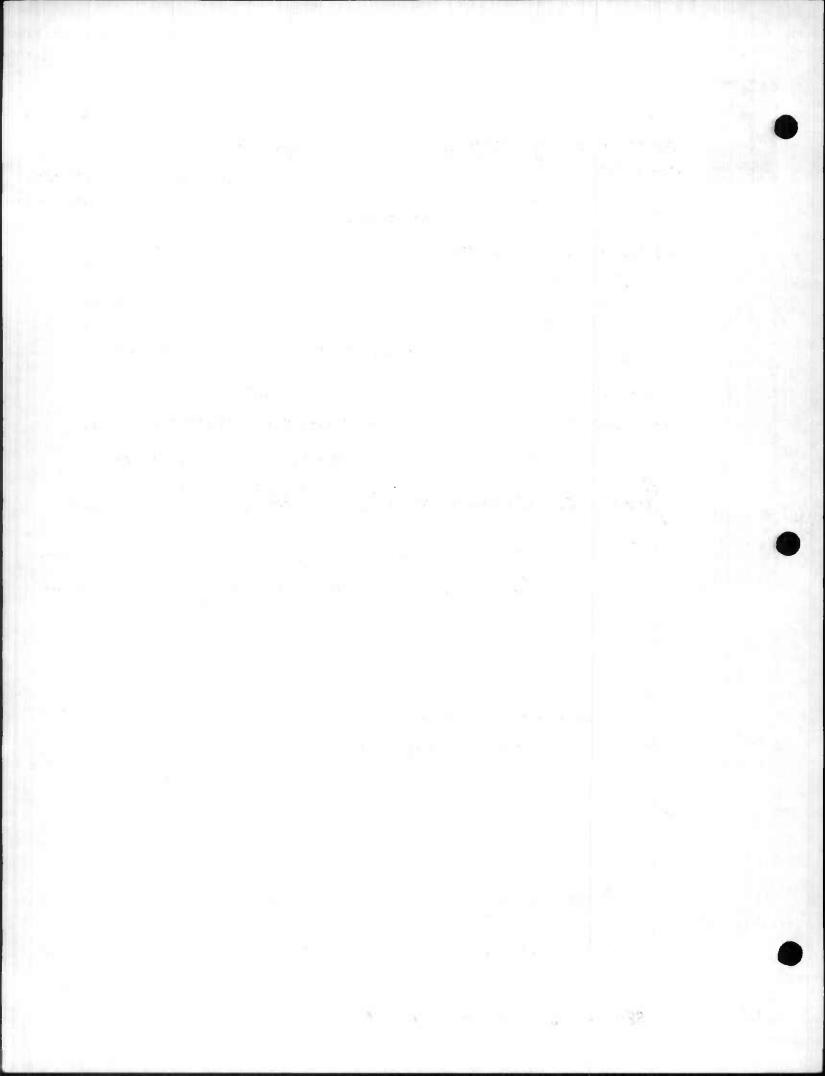


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Physicia		1. Decedent's Neme (First, Middle, Las	t)			-11	2. Data of Death Month		3. Time of Deel	
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ms 23a or 28a-f show	Funeral Director	10e. Street end Number 85 Hospital Road	f		10f. Zip Code 2(0678	10	g. Citizen of Wh USA	at Country?	
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ls m		19e. Informant's Neme/Reletionship (7			Meiling Address (Stree					
n 27			/ daughter			Church 1			n, MD 20639	
Department of Heatin a Important: If Item 27 is any Injury or other tra		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cramation 3 ☒ 4 ☐ Donetion 5 ☐ Other (Specify,		cametar	Disposition (Name of y, cremetory or other plants ry's Catho]		9-14-98	Needhar	m, MA	
Import any Inj once.		21. Signetura of Funerel Service Licans	Ston		22. Nama and Addr Rausch Ft	-	me, P.A.,	Owings	s, MD 20736	
		23a. Pert1. Enter the diseese, or comp shock, or heert feilure. List only of	lications thet caused t	he deeth. Do n					Approximete Intervel Between	
34		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury the Initiated avents resulting In deeth) Lest b. Due to (or es e consequence of): Cause (Disease or Injury the Initiated avents resulting In deeth) Lest Due to (or as a consequence of):								
		thet lillieted avents	c							
physicians the bur	edical	resulting In deeth) Lest	c							
by the attending physicia ached for use as the bur	Physician/Medical	resulting In deeth) Lest	c	ue to (or as a c	onsequence of):	ven in Pert I.	23b. Did tot 1 🗆 Ye			
gned by the attending physicle be detached for use as the bur	by Physician/Medical	resulting In deeth) Lest	c	ue to (or as a c	onsequence of):	iven in Pert I.		eutopsy 3	ibuts to the cause of dea	
ata has been signed by the attending physicla page 2 should be detached for use as the bur	by Physician/Medical	resulting In deeth) Lest	c	ue to (or as a c	onsequence of):	iven in Pert I.	1 ☐ Ye	e 2 4 No 3	24b. Were sutopsy finding evailable prior to completion of cause	
ata has been signed by the attending physicla page 2 should be detached for use as the bur	Completed by Physician/Medical	Pert II. Other algnificant conditions co	cD d ntributing to death but	ue to (or as a c	onsequence of): the underlying cause g	28. Place of Dec	1 Ve	eutopsy and a second se	Probably 4 Unkn 24b. Were sutopsy finding evailable prior to completion of cause of death?	
s cartificate has been signed by the attending physicle director, page 2 should be detached for use as the bur	Completed by Physician/Medical	Pert II. Other algnificant conditions co	c	ue to (or as a c	onsequence of): the underlying cause g	28. Place of Decher: 4 🖪 Nursing H	1 Ve	eutopsy sed?	24b. Were sutopsy finding evailable prior to completion of cause of death? 1 Yes 2 No	
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itter deam. Nector: After this cartificata has been signed by the attending physicia in by the funeral director, page 2 should be detached for use as the bur	To Be Completed by Physician/Medical	Pert II. Other algnificant conditions co	d	not resulting In t 2 ER/Out Year) 28b. T	the underlying cause g	28. Plece of De her: 4 A Wursing H iny et ink?	24e. Wes an perform 1 Yeseth (Check only one tome 5 Resides 28d. Describe hor	eet and Number	Probably 4 Unkn 24b. Were sutopsy finding evailable prior to completion of cause of death? 1 Yes 2 No	
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n 24 hours after death. • Funeral Director: After this cartificata has been signed by the attending physicial pletaly filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	ledical Certification: To Be Completed by Physician/Medical	25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Acident investigation 3 Sulcida 6 Could not be determined 29a. Certifier (Check only 2 Medical Exam)	d	t 2 ER/Out Year) 28b, T Ir y - At home, fer (Specify) my knowledge, xaminetion and	the underlying cause g the underlying cause g the underlying cause g the underlying cause g the underlying cause g the underlying cause g the underlying cause g the underlying cause g the underlying cause g the underlying cause g the underlying cause g the underlying cause g the underlying cause g the underlying cause g the underlying cause g	28. Place of Decimer: 4 Autrising Hard wirk? 1 Yes 2 No wine, deta end place opinion, deeth occurse number	24e. Wes an perform 1 Yeseth (Check only one tome 5 Resider 28d. Describe how city or Town, a, and due to the ceurred at the time, de	s 2 No s	Probably 4 Unkn 24b. Were sutopsy finding evailable prior to completion of cause of death? 1 Yes 2 No (Specify) or Rural Routa Number,	



		Ce	ertificate of	Death		Reg. No.					
1. Decedent's Neme (First, Middle,	Last)				2. Date of De		(7.5)	3. Time of Deeth			
/sician ledical <u>WIIIII</u>	BYRD				Month 09	Dey 03	Year 98	10:14 A			
4e. Facility Neme (If not institution,				4b. City, Town,	or Location of Deet			10.14 A			
WASHINGTON ADVI	NTTOT HOOD	TTAT		TAKOMA	DADIZ	MON	T. CO				
		TIAL ge (In yrs. last birthda)) If Under 1 Yeer								
579-16-3183	1 M 2□ F	83 Yrs.	Months Deys	Hours N				lace (State or Forei			
Usuel Residence of Decedent					2-28-	-13	POUTE	I CAROLIN			
10e. Stete 10b. County		10c. City, Town or I	ocation				1	0d. Inside City Limi			
D.C		WASH	INGTON					1 ▼Yes 2□N			
10e. Street end Number			10f. Zip Code			10g. Citizen of	What Cour	itn/2			
611 EDGEWOOD TI	ERR. APT.#	210	1.0	20018			5.A.	, .			
0					(Consity Van as N		ce - Americ	on Indian			
11. Marital Status DIVORCEI		NIO	Wes Decedent of I If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)	Bia	ck, White,				
3 Widowed 4 Divorced	If Yes, Give	No 210	1□ Yes 2□ No	Specify:		Specia	y: BLA	CK			
	Year or Detes:										
15. Decedent's (Specify only highest Elementery/Secondary (0-12)	grade completed)	16e. Deci	edent's Usuel Occu _l e <i>kind of work done</i> DO NOT use retire	petion during most of a	working	16b. Kind of B	usiness/Ind	dustry			
Elementery/Secondary (0-12)	College (1-4or	5+1	NSTRUCTIO			ROAD V	IOPV				
8		CO	NSTRUCTIO								
17. Fether's Neme (First, Middle, Li	ast)			18. Mother's h	Neme (First, Middle	, Maiden Sumai	ne)				
ALEX BYRD				FR	ANCES						
19e. Informent's Neme/Reletionshi	p (Type, Print)	19b. Mei	ling Address (Street	t end Number or	Rural Route Numb	er, City or Town	, State, Zip	Code)			
CAROLE GILMORE		660	7 5th STR	REET N.W	. WASHING	GTON, D. C	200)11			
20a. Method of Disposition		20b. Place of Disp cametery, cre	position (Neme of ematory or other pla	ice)	Dete	20c. Location	- City or To	wn, Stete			
1X Buriel 2 Cremetion 3 4 Donetion 5 Other (Spe				R HILL	9-14-98	SUITLA	ND MA	RYI.AND			
		2			7 14 70	DOTIM	1412 1111	KI LIIIID			
1000	21. Signature of Funeral Service Licansee 22. Name end Address of Facility THE HOUSE OF WILLIAMS FUNERAL SERVICE										
James E	, will	unis	2504_25th	STREET	N.E. WAS	SHINGTON	I,D.C.	20018			
23a. Part1. Enter the diseese, or ca chock, or heart failure. List or	omplications that caused aly one ceuse on eech li	d the deeth. Do not er ne.	nter the mode of dyi	ng, such es card	liac or respiratory a	irrest,		Approximete Interval Between			
Immediate Ceuse (Finel	0						1	Onset and Death			
Immediate Ceuse (Finel disease or condition resulting in death)	CARI	DIAC F	RKHYT	HULA			į.	3 WEEKS			
resulting in deeth)	A	DUAC F Due to (or es e conse	equence of):								
<u> </u>	ANTER	OSCLENA	TIC CA	EDIOVA.	SULAR	DISETT	TE	SYEARS			
Sequentially list conditions, if eny, leading to immediate case. Enter Underlying	D	Due to (or es e conse									
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events							į				
thet initiated events resulting in deeth) Last	С.	Due to (or es e conse	quence of):				1				
Ceuse (Diseese or injury thet initiated events resulting in deeth) Last							1				
	d										
Pert II. Other significant conditions STAPHYL	s contributing to death b	ut not resulting in the	underlying cause of	ven in Pert I	23b Dld	tobacco use co	ntribute to	the cause of deat			
hy s						Yas 2□ No	3 ☐ Prot	1			
STAPHYLO	OCOCCAL	JEPTIC	EMIA		_ ''	149 20110	0_110	A DE CHILLIA			
					24e. Wes	en eutopsy		ere eutopsy finding			
CONGESTION CONGESTION	VE HEAM	TOAI	LURE		perfe	ormed?	COL	allable prior to impletion of cause			
CONGESTION CORUMAN						17	of	death?			
	Y INISC	IFFICIE	7404		10	Yes 2 No	10	Yes 2□ No			
25. Was case referred to medical examiner?			1		Deeth (Check only	one)					
O No Yes 2 No	Hospitel: 1 Inpatie	ent 2 ER/Outpatie	ent 3 DOA	her: 4 \(\text{Nursing}	g Home 5 ☐ Resi	denca 6 🗆 Ott	ner (Specify	1)			
27. Manner of Deeth	28e. Dete of Inju (Month, Da	ry 28b. Time (of 28c. Inju Wo	ry et rk?	28d. Describe	how injury occur	rred				
2 Accident Investigat				Yes 2 No							
3 Suicide 6 Could no determine	t be ed 28e. Place of Inj building, et	ury - At home, farm, s	treet, fectory, office		28f. Location (Street end Numi wn, State)	ber or Rura	l Route Number,			
27. Manner of Deeth 1. Naturel 2	building, or	o. (Opcony)			0.1, 0.70	wii, biato,					
	Physician: To the best	of my knowledge, dee	th occurred et the ti	me, dete end ple	eca, end due to the	ceuse(s) and m	enner es st	eted.			
29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	aminar: On the besis of end manner ste	examination end/or In eted.	nvestigation, in my	opinion, deeth oc	courred et the time,	date end pieca,	end due to	the ceuse(s)			
29b. Signature and tille of normalier			29c. Licens	se number		29d. Date signe	ed (Month, i	Day, Year)			
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DEZINIS ITA	ND 470:	1 WUEER	is Breky		i) HYA	-1750166	t n	1) 20751			
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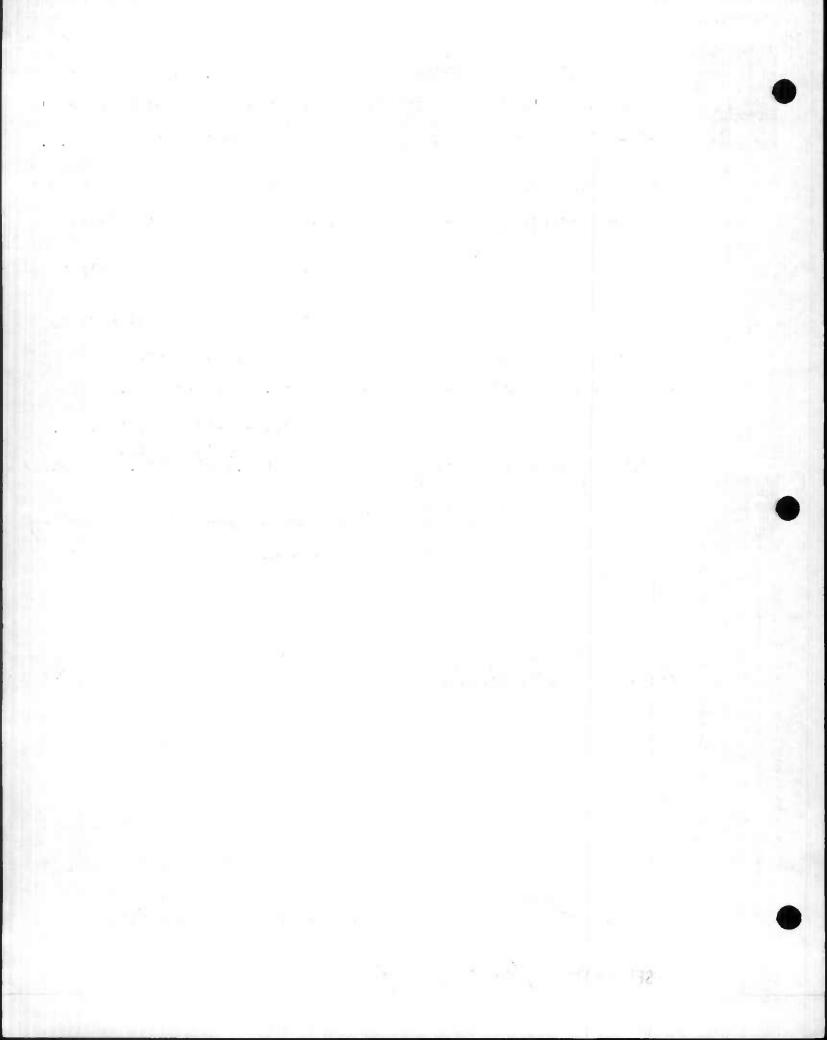


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death **Physician** SEPT. LURENZER BLACKBURN 1998 5:40 PM /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE S Hours Min. 8. Deta of Birth (Month, Dey, No v 20 7. Aga (In yrs. lest birthday) If Undar 1 Yaar Months Days 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2X)F 578-44-5561 Director N.C. Usual Rasidance of Decedant with the Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at ¥ Yes 2 No Director Prince Georges Landover 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 7413 Grayridge Lane 20785 United States permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23, any Injury or other traumatic event, the Magical Examiner mass. Funeral 12. Wes Decedant Evar In U,S. Armed Forcas? 1 ☐ Yes 2 ②No If Yas, Giva Yaar or Datas: 13. Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1 □ Navar Merried 2 □ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Spacify: þ Specify: 3 Widowed 4 □ Divorced Black Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Collega (1-4or 5+) Elemantary/Secondary (0-12) Housekeeper Housekeeping 17. Fathar's Name (First, Middla, Last) 18. Mofhar's Name (First, Middle, Maldan Surneme) Be Nathaniel Teasley 2 Juanita Harris 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 7413 Grayridge Ln. Frank Henderson Brother Landover, Md. 20785 20a. Method of Disposition 20b. Placa of Disposition (Nama of cemetary, cramatory or other placa) 20c. Location - City or Town, Stata Date 1 Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hills Cemetery9-11-98 Clinton, Md. bt Funeral Service Licenses 22. Nama and Addrass of Facility Capitol Mortuary Wash., 1425 Maryland Ave., NE 20002 DC or complications that caused the death. Do not enfer the mode of dying, such as cardiac or raspiratory arrast, Approximate Intarval Batween Onset and Death Physician /Medicai Immediate Cause (Final disaase or condition rasulting in daeth) Examiner Examiner ician and burial-transit rdice Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarfying Cause (Disaase or Injury that Initiated events rasulting in daath) Last Due to (or as a consequence of) physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part It. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 1 ☐ Yes 2 ☐ No p 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of causa of daath? 1 ☐ Yas 2 Ê No 25. Was case referred to medical examiner? 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Yas 200 No Inpatiant 2 ER/Outpatienf 3 DOA After this funeral 27. Manpar of Death Date of Injury (Month, Day Yaar) 28d. Dascribe how Injury occurred Certification: 28b. Time of 28c. Injury af Work? Natural 2 Accidant 5 Panding Invastigation 24 hours after death. Funeral Director: After 1 ☐ Yas 2 ☐ No 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 24 hours a edical 29a. Cartifier 1 Certifying Physicien: To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar stated. To the Within 2 To the F 29c. Licansa number 29d. Date signed (Mehth, Day, Year) 29b. Signatura and titla of certifiar 30. Name and andreas of person who completed cause of death (Item 23a) (Type, Print) James Catavenis, M.D. 3001 Hospital Drive Cheverly, MD 20785

Registrar

31. Data filed (Month, Day, Yaar) SEP 0 9 1998

22. Regisfrar's Signature



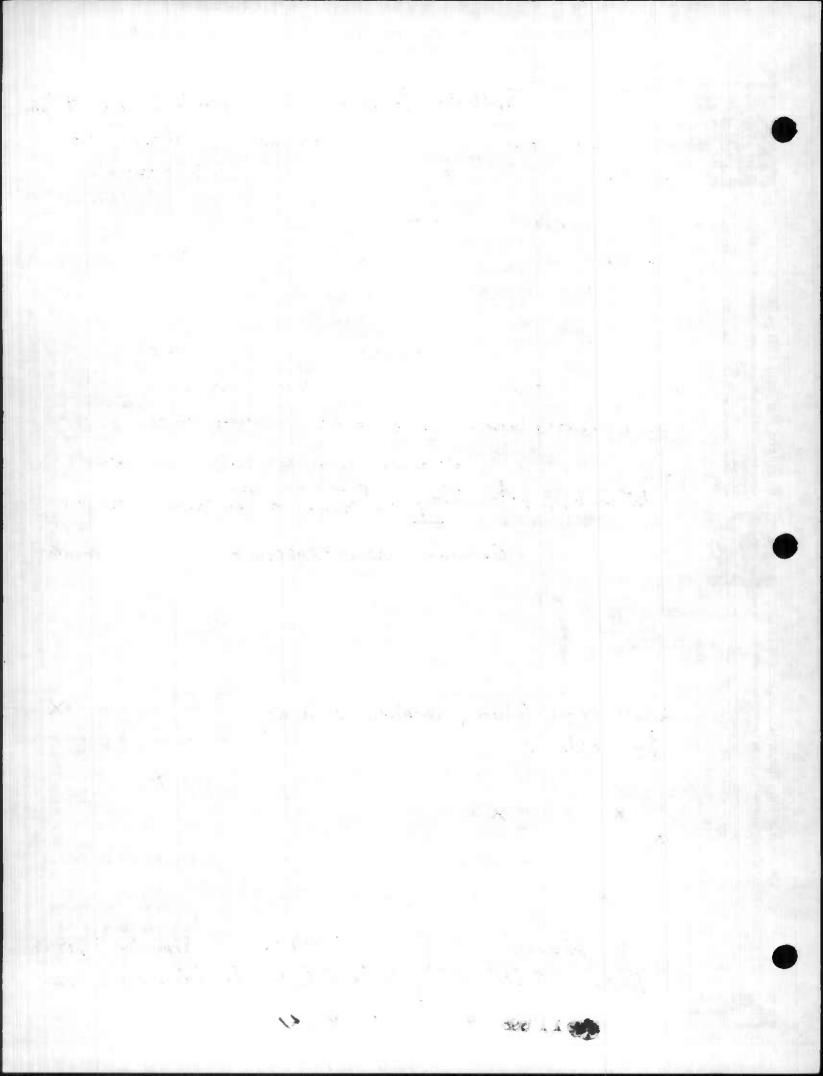
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Deta of Daath 3. Time of Death 1. Decedant's Nama (First, Middla, Last) September De Baumeist **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Nama (If not institution, giva street end number) Examiner Baltimore City Baltimore Mercy Medical Center If Undar 1 Year If Under 24 Hrs. Birthplace (Stata or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min Yrs. July 19, 1939 New York Director 59 110-30-2547 Usuel Residence of Decadant with the Menylend 10d. Inside City Limits 10a Stata 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Menylen Department of Health and Mentlet Hygiene. The important: If term 27 is marked other than "naturel; or itema 23a or 28a-f show eny injury or other traumatic event, its Mexical Examinar main handlind as 1 Yes 2 □ No Director Baltimore City Baltimore Maryland 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21209 United States 12 Wytchwood Court Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14 Race - American Indian Black, White, atc. 1 Nevar Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: White Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elementery/Secondary (0-12) Collega (1-4or 5+) self 12 Housewife 4 18 Mothar's Nama (First, Middla, Maiden Sumame) 17. Fathar's Name (First, Middla, Last) Be Emma Tausani Andrew Karch 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Nama/Ralationship (Type, Print) 12 Wytchwood Ct., Baltimore, Maryland 21209 Robert Baumeister / husband 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition 1 X Burial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) 9/12/98 Lewes, Delaware Saints Episcopal Cem 21. Signature of Funaral Sarvice Licansaa 22. Nama and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD o not entar tha mode of dying, such as cerdiac or raspiratory arrest. 23a. Part1. Entar the disease, or complications that ceusad tha death shock, or heert failure. List only one cause on each line. **Physician** months /Medical OVARIAN Immediate Ceuse (Finel CARCINOSARCOMA disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner certificate be executed been signed by the ettending physician and should be deteched for use as the bunal-transit Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Causa (Disaasa or injury Dua to (or es a consequança of): Box 68760, Physician/Medical that initiated evants rasulting in daath) Last Dua to (or as a consaguance of) 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. foilure 3 Probably 4 Winknown wetabolic 1 Yes 2 No by 24b. Wara autopsy findings sveilable prior to 24a. Was an autopsy parformad? Completed completion of cause of death? hes 1 Tas 1 TYas 2 No 25. Was cesa rafarred to madical axaminar? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1□ Yas 2 No 10 1 Inpatient 2 ER/Outpatiant 3 DOA this lunerel al or Attending Ph s after death. Il Director: After th 28d. Dascribe how Injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) Certification: 1 Natural 2 Accidant 5 Panding invastigation 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 3 Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 6 4 Homicida To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledga, death occurred at tha tima, deta and place, and due to tha causa(s) and manner es steted.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred et tha tima, data and place, end due to the cause(s) and manner stated. edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end titla of certifias 29c. License number madain 30. Name and address of person who completed pluse of death (Item 23a) (Type, Print) (Type, Print) (Type, Print) Balhiner Mp 2/202

State Registrar

PINIS 31. Data filad (Month, Day, Year)

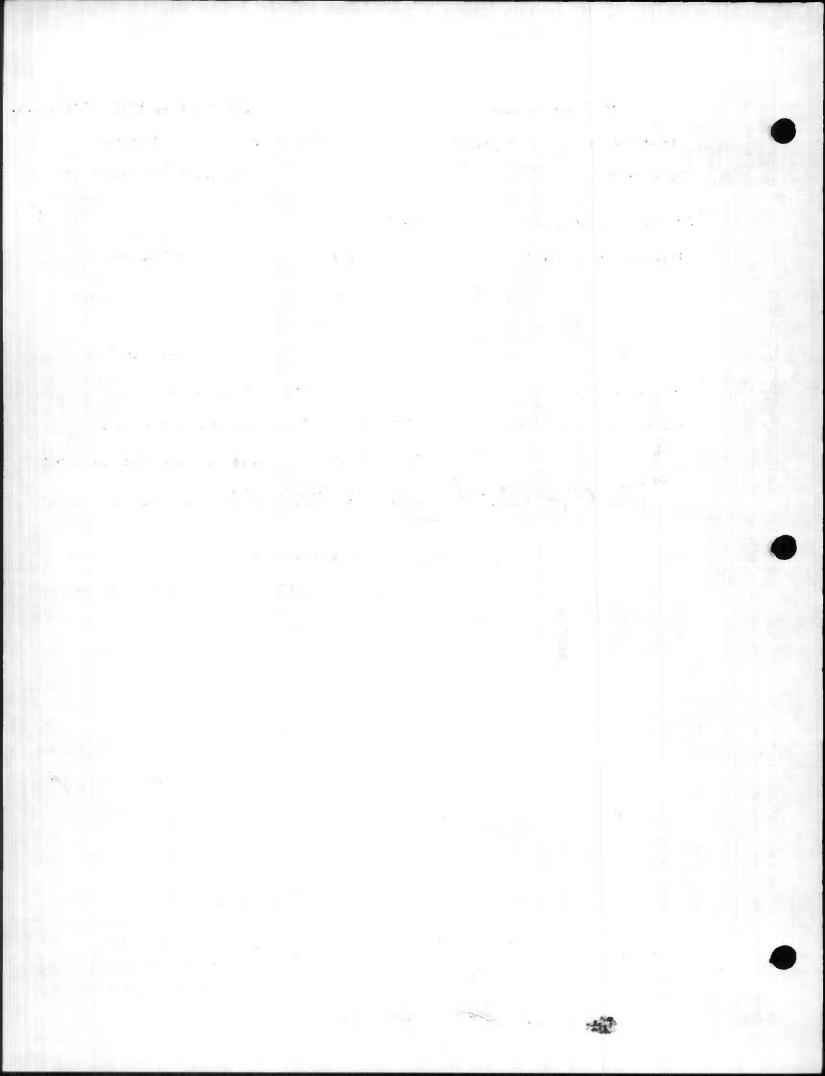
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Deeth Month Day Year **Physician** Walter Elwood Barnes September 7, 1998 12:43 P.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Frederick Frederick Memorial Hospital Frederick If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 6 Sax **Funeral** Hours Months 17 M 2□ F Davs 61 May 18, 1937 Director 214-36-9472 Maryland Usual Residence of Dacedan death with the Maryland 10c. City, Town or Location 10d. Insida City Limits 10a Stata 10b. County Peges 1 and 2 should be filed within 72 hours efter death with the Marylan neat of Haath and Mental Hygiena. In the Marylan int: If then 27 is marked other than "natural; or items 23a or 28a-f show yor other traumatic event, the Medical Examine must be notified at my 1 Yas 2 No Directo Maryland Frederick Frederick 10a. Citizen of What Country? 10e. Street and Number 10f, Zip Coda 10200 Winston Drive 21701 United States Funerai 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No ff Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black White atc. 1 ☐ Navar Married 20XMarried Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: white Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Dacedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry College (1-4or 5+) Elementery/Secondary (0-12) 10 Mechanic Aluminum Ind. 18. Mothar's Nama (First, Middla, Meidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Cletus E. Barnes Charlotte L. Clem 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 10200 Winston Drive, Frederick, MD Patsy L. Barnes / wife 21701 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata permit. Pege Department o Important: If any Injury or Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 9/14/98 Frederick, Maryland 21. Signature of Funeral Service Licenses 2. Nama and Addrass of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD enter the mode of dying, such as cardiac or raspiretory arrest, 21702 23a. Part1. Entar tha disaasa, or complications that caused tha daath_shock, or haart failura. List only ona causa on each lina. Approximate Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final FIBRILLATION HIL disaasa or condition resulting in death) VENTRICULAR Examiner Due to (or es a consequence of): Examiner CARDIO - VASC DISEASE LTERIOSCLERATIC physician and the buriel-transit that the deeth certificate be axecuted Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Ceuse (Diseasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consaguance of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) ettending pl signed by the e 23b. Did tobacco use contributa to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yas 2 No 3 Probably 4 KUnknown by 24b. Wara autopsy findings available prior to complation of causa 24e. Was an autopsy Completed pege 2 has 2000 1 Yas 21 No 1 ☐ Yas certificata Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice funeral director, 25. Was casa rafarred to medical axaminar? Be 28. Plece of Death (Chack only one) Other: 4 Nursing Home 5 Rasidance 8 Othar (Specify) 0 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Menner of Daeth 28b. Time of Certification: 5 Panding investigation 1 Natural 1 Yas 2 Accidant 3 Suicida 6 ☐ Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) illed in by 4 Homicida 24 hours a Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the ceuse(s) end mennar as stated.

2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and mannar stated. To the Hospi within 24 hou To the Funer completaly fil 29a. Cartifier Medical (Check only one) 29d. Data;signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certifiar ND. daath (Item 23e) (Type, Print) 30. Nama and addrass of person who complated causa of VICE PAR LED AFFMR; FREDERICK GEORGE 1. SMITH 31. Data filad (Month, Day, Year) 32. Ragistrar's Signatura State פבנו

Registrar



State of Maryland / Department of Health and Mental Hygi

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the Mary 28a-f sh notified.s	Directo	MARYLAND SOMERSE 10e. Street and Number	:	l CF	RISFI	LU 101. Zij	Cada			10a Cilina	of What Cou		
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or Nerte 2 cor Nerte 2 miner ma	Funeral	11. Merital Stetus 1 Never Merried 2 Merried	12. Was Deceden Armed Forces 1 Tyes 22	\$?	,S. 1:	13. Was Decedent of Hispanic Origin? (Specify Yell If Yes, specify Cuban, Mexican, Puerto Rican, e							
21215-0020 d within 72 hours at pient. r than 'natural', or the Medical Exami	d by	3 Widowed 4 Divorced	If Yes, Give Yeer or Detes	:		1 ☐ Yes	214 No	Specity:		Sp	ecity: W	HITE	
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rland in be file fental Hy read other fic event	0 8	JASON MILLER						CATHER	INE F. N	ICHOLA	S		
and war		19e. Informent's Neme/Reletionship (Type, Print)		19b. Me	eiling Addres	S (Street	and Number or	Rural Route Num	ber, City or To	own, State, Zi	ip Code)	
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Baltimore, semit. Pages 1 ar appartment of Hea iny Injury or othe stice.		20a. Mathod of Disposition 1 Buriel 2 Cremation 3 5 4 Donetion 5 Other (Specia		e C	emetery, c	sposition (Na remetory or o	other pla		Date 9/9/98		ion - City or T BURY , I	own, Stete MARYLAND	
Ball Department of the part of		22. Name and Address of Facility HINMAN FUNERAL HOME MO0295 11673 SOMERSET AVE. PRINCESS ANNE, MD. 21853 Approximate Interval Service Licensee Approximate Interval Servic											
Physician /Medica Examine	r r	Immediate Cause (Finel disease or condition rasulting in deeth)	ofun .	C W	MO((No econoupee	1pl	inter	robur			Onset and Deat	
of Vitai Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rel director, page 2 should be detached for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last	c. 400m	Due to (o	es a cons	sequence of):	<i>~ /v</i>	~ (N)	1716	000001	Hon		
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		30. Neme and address of person who	completed cause of	death (Item	1 23a) (Typ		,	/					
		JANET WASSON M		CARRO	145	t. SA	Hisk	uny M	d				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** DEPTEMBER 8, 1998 GEORGE A. 2009 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO H Under 1 Year H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Min. June 20, 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** MM 2DF 235-30-8418 72 Yrs. Director Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show Maryland Somerset Crisfield 1 Yes 2 No Directo must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or llams 23s or 3954 Cardinal Drive 21817 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. hours after 1 N Yes 2 No 11/18/44 If Yes, Give Year or Dates: _ 5/7/47 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 20 No Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipyard Supervisor Bethlehem Steel Grade 10 permit. Pages 1 and 2 should be fin Department of Health and Mental Hy Important: If Item 27 is marked oths any Injury or other treumedic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Ball Lillian Stillwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June F. Ball (Wife) 3954 Cardinal Drive - Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 2 Burial 2 Cremation 3 Removal from State Sunnyridge Memorial Park 9/11/98 Crisfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, Jr. 306 W. Main St. Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Renal FAILURE disease or condition resulting in death) Examiner Examiner physician and s the burlal-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Due to (or as a consequence of): ... P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed paga 2 1 Yes 2 No 1 Yes 2 No Vital Attending Physician: funeral director 25. Was case referred to medicat B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To of this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Division 1 2 Natural 5 Pending 1 Yes 2 No death. investigation n 24 hours after death we Funeral Director: / plataly filled in by the 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 6 Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier edical within 24 hor To the Fune completely fi (Check only one) the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 24872 who completed cause of death (Item 23a) (Type, Print) · SALISBURY MA 560-RIVERSIDE PR 12URY 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** ber 4, 1998 4b. Cify, Town, or Location of Death Kay Ann Culler /Medical 2/320 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 119 Bywood Road Elkton Cecil. if Undar 1 Yaar If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Months Days Hours 1 □ M 200 F Yrs Director 222-34-6145 October 16, 1950 Delaware Usual Rasidenca of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a4 show treumatic event, the Medical Examiner must be not the dist 1 ☐ Yes 2 X No Directo Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 119 Bywood Road United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. filed within 72 hours aftar 1 ☐ Yes 2√ No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 Yes 2√ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 W.L. Gore Supervisor 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I Joseph Wilson Stoops Gladys Fitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) Health a Ronnie Culler/ husband 119 Bywood Road, Elkton, Maryland 21921 or other t 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Ramoval from State September 10, 4 Donation 5 Other (Specify) Elkton Cemetery 1998 Elkton, Maryland 22. Nama and Address of Facility
Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 West Stockton Street, Elkton, Maryland 21921 2) 353 23a. Part 1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Breast Cancer /Medicai Immediate Cause (Final disease or condition rasulting in death) Examiner 2 years Due to (or as a consequence of): Examiner The law requires that the death certificata be axecuted Sequantially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Disaase or trijury that initiated events resulting in death) Last the bunal-tran and Due to (or as a consequence of): Physician/Medicai Due to (or as a consaquence of) use as ate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy parformed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 200 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4☐ Nursing Home SX Restdenca 6 ☐ Othar (Specify) 1 Yas 20 No Certification: To this funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascriba how injury occurred After 1 Naturat 5 Pending death. 1 Yes 2 No investigation 2 Accident in by tha within 24 hours aftar deat To the Funerel Director: 3 Suicide 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicida Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Cartifier 943 29b. Signatura and titia of cartifian 29c. License number 29d. Date signed (Month, Day, Yaar) 30. Name and addrass of parson who complated cause of death (Item 23a) (Type, Print) INOrthern Chesapenke Hospice, Elkton, MD ar kas 31. Date filed (Month, Day, Year) State

Registrar

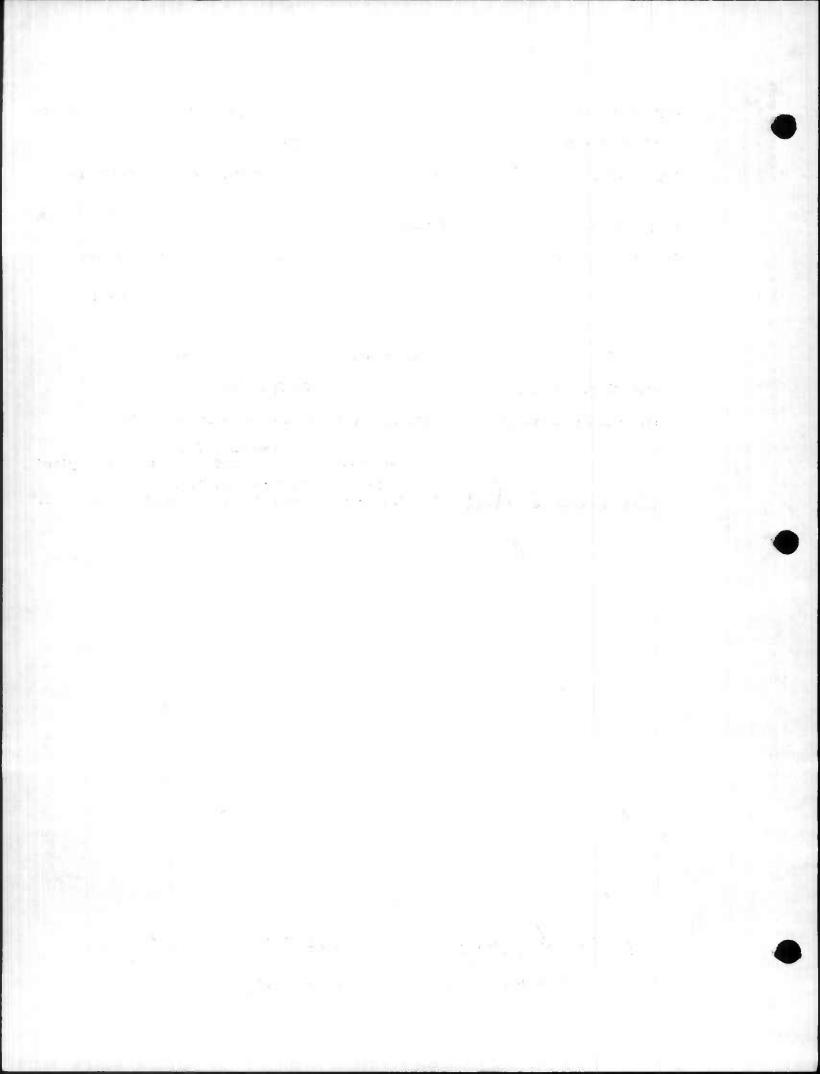
SEP 1 0 1998

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month PEARL E. CULLEY 9 SEPT. 1998 8:51 pm 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death ANNAFOLLS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Dey, Ye. MARCH 15 806 CHESTNUT TREE DRIVE ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign Year) Months 1 M XXXF MARYLAND 1927 71 214-44-8338 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US DRIVE 21401 806 CHESTNUT TREE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Merital Stetus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced BLACK Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) US NAVAL Elementery/Secondary (0-12) College (1-4or 5+) 0 SEAMTRESS 12th ACADEMY 17. Father's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) PEARL JOHNSON ALLEN TURNER 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 806 CHESTNUT TREE DRIVE ANNAPOLIS, MD. 21401 MARIA GREEN (DAUGHTER) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete CEME 9/14/98 CROWNSVILLE, MARYLAND VETERAN 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. Leese arry 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death artenoscherotic comany vascular disease Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest Due to (or as a consequenca of). Due to (or es e consequence of): 23b. Did tobacco uss contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy performed' 1 Ves 2 NO 1 TYes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

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Examiner physiclan and the bunal-tran Physician/Medical 98 5 s been signed to should be detail by Completed hes paga 2 certificate Hospital or Attending Physician: 24 hours efter daath. Funeral Director: After this certifics Be 2 funeral Certification:

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Medical

3 Suicide

The law requires that the death certificate be asscuted

Division of Vital Records, P.O. Box 68760,

6 Could not be determined

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5. Was ease referred to medical examiner?				26. Plece	e of Death (Che	eck only one)		
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpetient	3□ DOA	Other: 4 N	ursing Home	5 M Residenca	6 □Other (Specify)	
7. Manner of Death 1. Naturel 5. Pending 2. Accident Investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury		Injury at Work? 1 Yes 2	28d. [Describe how Inju		

 Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as steled.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signatu

30. N ed cause of death (Item 23a) (Type, Print)

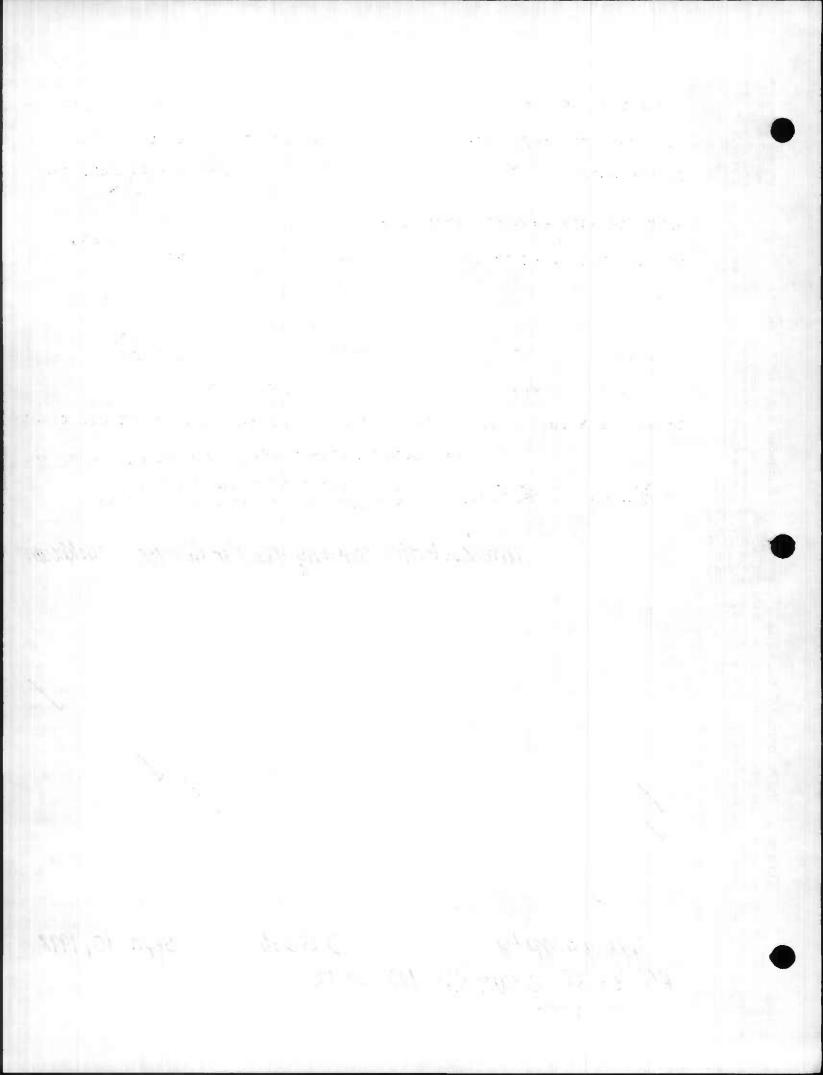
Dr. Jeffrey Briggs 31. Date filed (Month, Dey, Year)

State Registrar

in by

n 24 hours of filled

To the Vithin 2



State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 24A, 27, 28A-F PER MEO G769 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time III Death September 8, 1998 **Physician** 2:20 FM Criss Harley Hampton /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 2147 Thomas Run Road Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Year) 5. Sociel Security Number 8. Deta of Birth (Month, Dey, Year)
March 6, 1930

9. Birthplaca (State or Foreign Country)
West Virginia 7. Aga (In yrs. last birthdey) **Funeral** 1₩ 2□F Yrs. Director 214-26-7492 68 Usual Rasidance of Decedent tha Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yas 2 No Director Harford Maryland Bel Air 10g. Citizen of What Country? -10e. Street and Number 10f. Zip Coda 2147 Thomas Run Road 21015 USA Funeral 12. Was Dacedant Ever in U.S. Armed Forcas? 1 ☐ Yes ≥ 2 No If Yes, Giva Yaar or Datas: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 72 hours aftar 1 ☐ Naver Merried 2 ☐ Marriad altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowad 4 Divorced Completed 15. Decedant's Education (Specify only highast grade complated) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 18b. Kind of Businass/Industry illed within 7 Hygiena. Elamantary/Secondary (0-12) College (1-4or 5+) Butcher Shop permit. Peges 1 and 2 should be filed wit Department of Haaith and Mental Hygiens Important: If Itam 27 is marked other that eny injury or other traumatic event, traugate, 6 Butcher 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Harrison Lee Criss Georgia (u/k) Pritt 19a. Informant's Name/Ralationship (Typa, Print) 19b. Melling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Theodore H. Criss - son 3911 Rocks Rd., Street, MD 21154 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata Hilltop Service Corp. 9-11-98 Towson, Maryland 4 ☐ Donetion 5 ☐ Othar (Spacify) 21: Signature of Funeral Service Licenses 22. Nama and Address of Fecility
Howard K. McComas III Funeral Home, P.A. Comas 1317 Cokesbury Rd., Abingdon, MD 21009 23a Part1. Enter the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiratory arrest, shock, or hear dailure. List only one cause on each line. **Physician** CHEST INJURIES COMPLICATED BY MYOCARDIAL INFARCTION /Medical Immediata Causa (Final Sudden diseasa or condition rasulting in deeth) Examiner Dua to (or es e consequança of): Rib + Clavide Fractures physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Diseesa or Injury that initiated evants rasulting in death) Lest Dua to (or es a consequance of): Box 68760 Physician/Medical Dua to (or as e consequence of): attending | P.O. 1 Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary Disease 2 1 PYes 2 No 3 Probably 4 Unknown signed by Records, by 24a. Was en autopsy performad? 24b. Ware autopsy findings avelleble prior to completion of cause of daath? Completed Coronary Artery Discase APPROVAL Alcoholism 1 X Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital i or Attending Physician: after death. 25. Was casa rafarred to medical Be 26. Pleca of Death (Check only ona) examiner? 1 ☐ Yas 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Masidance 8 Othar (Specify) 2 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: Aftar 5 Panding invastigation Injury 1 ☐ Yas 2 ☐ No SUBJECT FELL AT HOME AUG. 31,1998 UNKNOWN Director: / 2 Accidant 6 Could not be datarmined 3 Suicide 28a. Piace of Injury - At homa, farm, street, factory, office building, atc. (Specify)
HOME 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 | Homicida To the Hospital o within 24 hours af To the Funeral Di completely filled in 2147 THOMAS RUN RD. BEL AIR, MD 1 Certifying Physician: To the best of my knowledga, death occurred at tha tima, deta end place, and dua to the cause(s) and mannar as stated.
2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) end manner steted. Medical 29a, Certifier 29b. Signetura end title of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) ller D35012 September 10,1988 30. Nama and address of person who complated causa of death (Itam 23e) (Type, Print) North Ave Bel Air, Md. 21014 J. Kevin Lynch 31. Data filed (Month Day, Year) 32. Registrer's Signatura State Registrar

erson in injure? Yello 1007 120 S etch II i Fe N

State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate o	f Death		Reg. No.		
Dhucis	ion	1. Decadant's Nama (First, Middle, L	ast)					2. Dala of Das Month		Year	3. Tima of Death
Physic /Med		Mildred Octavia	Knight C	arsin	s			Sept.		998	7:15 pm
Exam		4a. Facility Nama (If not institution, g	iva street and number	r)			4b. City, Town, o	r Location of Death	4c. County	of Death	
		4127 Prospect R					Whitefo		Har	ford	
Funera Directo		5. Social Sacurity Number 6. 218-07-0563 Usual Rasidanca of Dacedant	Sax 1□ M X F	95	last birthday) Yrs.	If Under 1 Ya			1903	9. Birthple Count	aca (Stata or Foreign
show a show	_	10a. Stata 10b. County			y, Town or Loc	ation				10	d. Inside City Limits
No M	octo	MD Harfo	rd	Wh	iteford						
Vith th	급	10e. Street and Number				10f. Zip Code			10g. Citizan of V	What Count	ry?
eth v	rai	4127 Prospect R				2116			USA		
s 1 and 2 should be filed within 72 hours efter deeth with the Menyland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at	by Funeral Director	11. Marilal Stalua 1 Navar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedan Armad Forcas 1 Yas 2X If Yas, Giva Yaar or Datas	?] No		/as Decedant of Yas, specify Co	f Hispanic Origin? (uban, Maxican, Pua lo <i>Specify:</i>	Specify Yas or No- into Rican, atc.)	14. Rac Blac Specify	e - Amarica ck, Whita, a	tc.
72 ho	Completed	15. Decedani's I (Specify only highest g	Education		16a. Deced	ant's Usual Occ	cupation	ortina	16b. Kind of Bu	usinass/Ind	ustry
within 7 ene. than "r	ple	Elemantary/Secondary (0-12)	Collega (1-4or	5+)	life. D	O NOT usa reti	ne during most of w ired)	orking			
filed with Hygiene. ther then	50	9th			S	ales CI	erk		Depart	ment	Store
d 2 should be file th and Mental Hy 7 is marked othe traumatic event	Be	17. Fathar's Nama (First, Middla, Las	t)					ama (First, Middle,	Melden Sumem	10)	
should be nd Mental marked o	0	Henry Archer F	Cnight				Florence	e Sitzler			
2 she and is me		19e. fnformant's Name/Relationship	(Type, Print)		19b. Meiling	Addrass (Stre	et and Number or I	Rural Route Numbe	r, City or Town,	Stete, Zip	Code)
1 and Health em 27		Marceline Steph	ens- Daug	hter	320 F	ox Rd	Havre o	de Grace,	MD 2	1078	
permit. Pages 1 and Department of Health important: If Item 27 any injury or other tronce.		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3	Removal from State	20b. P	laca of Dispos emetery, crem	ilion (Neme of atory or other p	place)	Data	20c. Location -	City or Tov	vn, Stala
permit. Pages Department of I Important: If Ite any injury or or once.		4 □ Donation 5 □ Other (Spec			ck Rur	n Ceme	tery	9/5/98	Havre	de G	race, MD
death certificate be executed e attending physician and ad for use es the buriel-transit	Medical Examiner	Immediata Causa (Final disease or condition rasulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Causa (Disease or injury that initiated evants rasulting in deeth) Last	a	Dua to (or	r as a consequence of the conseq	mice of):	hart fidl tiology	(ne) (not deter	unel)		25- 5- 10
the death cert y the attendin sched for use	sicia	Part II. Other significant conditions	contributing to death	but not rasu	ulting in the un-	derlying causa	givan In Part I.	23b. Dfd t	obacco use cor	ntribute to	the cause of death?
The lew requires that the de ste hes been signed by the a page 2 should be dateched i	by Physician/							101	2 2 NO	3 Prob	ably 4□Unknown
v require been sig should b								24a. Was			a autopsy findings
lew rec hes bee je 2 sho	Completed							parfor	med?	con	llabla prior to plation of cause aath?
	Co							1 🗆 Y	as 22 No	1 🗆	Yas 2 No
dcian: The	Be	25. Was casa rafarred to medical axaminar?					26. Placa of Di	eath (Check only o	ne)		
0 0	0	1 □ Yas 25 No	Hospilal:	iant 2	ER/Outpatient	3□ DOA	Othar: 4 - Nursing	Homa 52 Resid	enca 6 DOth	ar (Specify,	
Attanding Phor death.	1 1	27. Manne of Deeth 1. ■ Natural 5 ■ Panding 2 ■ Accidant Investigation		ury ay Year)	28b. Tima of Injury	28c. In W M 1	jury at /ork? □ Yas 2 □ No	28d. Dascribe h	ow Injury occurr	red	
To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicida 6 Could not datarmine	building, a	tc. (Specify	/)			28f. Location (S City or Tow	n, Stete)		
Hosp 4 hou Fune taly fil	edical	(Check only 2 Medical Exa	hysician: To the best miner: On tha basis o	of axaminat	wledge, deeth	occurred et tha	time, data end pied	e, end due to the coursed at tha tima, o	ause(s) and ma	nnar as sta	ited. tha ceuse(s)
the hin 2 the hin 2	Med	one)	and mannar s	tated.							4
T vib	~	29b. Signatura and title of certifier	t-MI	/		L	27/5	4	9d. Data signed	14/	198
5		30. Name and address of person who	complated causa of	death (ftem	23a) (Type, P	rint)	re de l	STORD L	1D 211	STC	
St	ate	31. Data filed (Month, Day, Year)	32 Regist	rar's Signat		Sour.	1	306,1-	ماعق ري.	- 10	

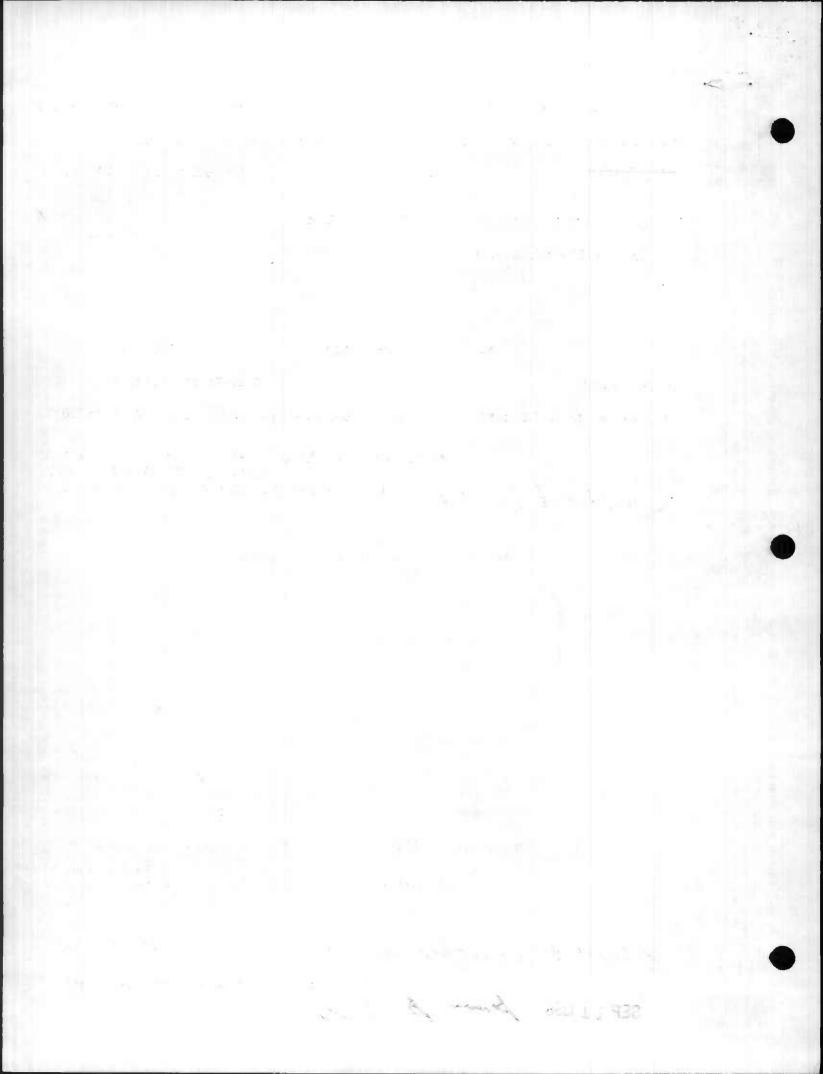
111 Penn Street, Baltimore, Maryland 21201

State Registrar 30. Neme end eddrass of person who complated cause of deeth (Item 23a) (Type, Print) Radentz

Stephen S.

DHMH 16 Rev 6/95

10



			State of	Marylan		artment of rtificate of		d Mental Hy	giene 🥞 🥱 Reg. No.	29303
Physic /Medi	cal	1. Decedent's Name (First, Middle,	(OURT	NRY	1	4. 00. 7-	2. Dete of De	002 -	3. Time of Death
Exami	ner	4a. Fecility Neme (If not institution, FEARTLAND HI 5. Social Security Number 6	EALTH CA	RE CE	NTER	If Under 1 Yeer	HYAT	TSVILLE	PRIN	ICE GEORGE'S
Funeral Director		231-98-8696 Usual Residence of Decedent	1 1 1 1 1 1 1 1 1 1	'. Age (In yrs.	8 Yrs.	Months Deys		Min. JULY 3	1, Year) 196	9. Birthplece (State or Foreign Country) VIRGINIA
deeth with the Maryland me 23e or 28e-f show Linual be notified at	tor	10a. Stete 10b. County	FAIRFAX		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with the M 23a or 28a-f	al Directo	10e. Street end Number 7529 REPUBLIO		#102		10f. Zip Code	2306		10g. Citizen of V	
P 2 2	by Funeral	11. Manitel Stetus 1 X Never Married 2 Memier 3 Widowed 4 Divorced	12. Wes Deced Armed Ford 1 Yes 2 If Yes, Give Yeer or Det	es? XNo		Wes Decedent of f Yes, specify Cub I ☐ Yes 2 💆 No		? (Specify Yes or No uerto Rican, etc.)		e - American Indian, ck, White, etc. /: BLACK
vithin 72 and.	Completed	15. Decedent's (Specify only highest of Elementery/Secondery (0-12) 12th	Education grade completed) College (1-4	4or 5+)	(Give	lent's Usuel Occu kind of work done DO NOT use retire	during most of ed)	working		aL GOVT.
be file that Hydrothe event,	To Be Co	17. Fether's Neme (First, Middle, Le MELVIN COURT	TNEY		TROC	MAII AIV.	18. Mother's	Neme (First, Middle,	Meiden Sumerr	
Fe, s 1 an s 1 an s 1 an other		19e. fnforment's Neme/Reletionship SANDRA COURT! 20e. Method of Disposition 1 Burlei 2 Cremetion 3	NEY/ SIS	ete	291 Plece of Disponentery, crem		SIDE	DRIVE AI Dete CEM. 9-5-	EXANDR 20c. Location -	
Baltimo pemil. Page Department o Important: If any injury or once.		4 Donetion 5 Other (Spe 21. Signeture of Funeral Service Lic	1 4	axt	22	. Neme end Addr	ess of Fecliity		S FUNER	AL HOME OF MD 20746
Box 68760, deeth certificate be executed the examiner of the continuation of the conti	an/Medical Examiner	23e. Pert1. Enter the disease, or co shock, or heert feilure. List on Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	e. b	Due to (o	r as e conseq	uence of):	CHTDR UL	and or respire to y	ALUR	Approximate Interval Between Onset end Deeth
P.O.	by Physician/Me	Pert II. Other significant conditions	contributing to dea	th but not resi	ulting In the ur	derlying ceusa gi	ven in Pert I.	23b. Dld	V.	ntribute to the cause of death? 3 Probably 4 Unknown
Rec lew has b	Completed								en eutopsy med?	24b. Were autopsy findings evallable prior to completion of cause of deeth?
_ F # &	Be	25. Wes case referred to medical examiner?	Hospitel:			0:	28. Plece of	Deeth (Check only o		1 □ Yes 22 No
Phys al di	Certification: To	1 Yes 2 No 27. Marner of Deeth Naturet 5 Pending investiget 2 Accident 5 Could not	28a. Dete of Menth,	Injury Sey Yeer)	ER/Outpatlen 28b. Time of Injury	28c. Inju	Nursir	N	now Injury occur	red
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		4 Homicide determine	building	est of my know	wledge, deeth	occurred at the ti	me, dete end p	lace, end due to the	Cause(s) end me	er or Rural Route Number,
To the Hospital within 24 hours. To the Funeral completely filled	Medical	(Check on 2 Medical Exicons) 20 Medical Exicons 20 Figure and title of occides	aminar: On the bas and manne	s of examinet	ion and/or Inv	1	opinion, death o			and due to the cause(s) d (Month, Dey, Year)
(10)		30. Name and address of person wh	o completed cause	of deeth (item	23e) (Type, I	24 7 3c	DVA	N JUS	RW.	Rd 1998
Sta Registr		31. Date fled Month, Day Years 99	8)LMA pistrar's Signa	M. S.	LAU	HI	MD	21)+0J

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	DDG		
	Physic /Medi Exami	cal	1. Dec C
	Funeral Director		49 5. Soc 5
	ages 1 and 2 should be filed within 72 hours after death with the Manyland and cf Haalth and Mental Hygiens. It: If frem 27 is marked other than "nature!, or itsma 23s or 28s-f show y or other traumatic event, in Medical Examiner must be notified as	To Be Completed by Funeral Director	Usual 10a. S Mar 10e. S
more, Maryland 21215-0020	within 72 hours after and and and and and and and and and and	mpleted by Fi	1[3[
rland 2	ages 1 and 2 should be filed with ant of Health and Mental Hygiena. It: If Item 27 is marked other that y or other traumatic event, the Item	ro Be Co	17. Fe
, Mary	s 1 and 2 should the stand to the stand the stand the standard other traumming the standard s		19a. I
nore	ages 1 and of He		20e. N

3. Time of Death edent's Neme (First, Middle, Last) 2. Date of Death Month 1900 harles Fredrick Carson SEPTEMBER 4, 1998 4b. City, Town, or Location of Deeth cility Neme (If not institution, give street end number) 4c. County of Death 5 AND ROUTE 4 UPPER MARLBORO PRINCE GEORGES 8. Date of Birth (Month, Day, Year) June 23 1965 ial Security Number If Under 1 Year 7. Age (In vrs. lest birthday) 9. Birthplaca (Stete or Foreign 1 M 2 □ F Months Deys Hours 78-98-5762 Wash., D.C. 33 Yrs Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Prince George's yland District Heights Street and Number 10f. Zip Code 10g. Citizen of What Country? 1772 Addison Road South 20747 United States 14. Raca - American Indian, Black, White, etc. 12. Was Decadent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) aritel Status 1 Yes 2 No
If Yes, Give A
Yeer or Detes: Never Married 2 Married Specify: Black 1 Yes 2 No Specify: ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) mentery/Secondary (0-12) College (1-4or 5+) Facilities Manager Private ther's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charlie Carson, Jr. Naomi Wood 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Intormant's Name/Relationship (Type, Print) Evelyln Williams - Aunt 4346 - 23rd Place, Temple Hills, MD 20748 Method of Disposition

∆ Burial 2 □ Cremation 3 □ Removal from Stete 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Harmony Memorial Park 9/12/98 Landover, MD □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses Stewart Funeral Home 4001 Benning Rd., N.E., Wash., D.C. 20019 rowell Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, or heert failure. List only one ceuse on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final of the head Gunshot disease or condition resulting in death) wound Due to (or as e consequence ot): Examine Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or es e consequence ot): Physician/Medical Due to (or as a consequence ot) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 25 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en autopsy performed' 1 PYes 2□ No 10 Yes 2 No 25. Was case reterred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2□ No Certification: To 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 Neturel 5 Pending 1 Yes 2 No

that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760, 88 980 signed by the a d be detached f nis certificate has b Attending Physician: this funeral death. ector: e Hospital or Al 24 hours after e Funerel Direc To the Hosp within 24 hor To the Fune completely fi

Physician /Medical

Examiner

Medical

29b. Signature and title of certifier 30. Name end address of person who completed cause of death (flem 23a) (Type, Print)

9-4-98

29c. License number O.C.M.E.

Highway in Cat Prince Georges County, Mary long

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

XX Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steted.

29d. Dete signed (Month, Day, Year) SEPTEMBER 5, 1998

Subject was Shet
281. Location (Street and Number or Rural Route Number,
City or Town, Stete) L-495 and Route 4

Stephen S. R 31. Date tiled (Month, Day, Yeer) SEP 0 9 1998

Investigation

6 Could not be determined

2 Accident

3 ☐ Suicide

29e. Certifier

4 Homicide

(Check only one)

111 Penn Street, Baltimore, Maryland 21201

State Registrar Radentz, 32 Registrar's Signature boards

1750

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 9 3 0 5

				Certifica	te of D	eath	Re	g. No.		
	1. Decedent's Name (First, Middle, La	est)					2. Dete of Deeth Month	Dev	Yeer	3. Time of Death
nysiçian Medical	Gordon Eugene	Cissel					Septembe			2:45 pm
miner	4e Facility Neme (If not institution, given	ve street and number)			4b	. City, Town, or I	ocation of Deeth	4c. County	of Deeth	
al or	220-32-6239		(In yrs. last birtl	if Undo irs.	r 1 Yeer	Churchto If Under 24 Hrs. Hours Min.		Year)		e1 ce (State or Forei l'land
	Usuel Residence of Decedent 10e. Stete 10b. County		IOc. City, Town	or Location					104	I, Inside City Limit
-									100	1. Inside City Linin:
Director	Maryland Anne Ar	undel		Churcht			1			
	10e. Street end Number			101. 2	p Code		10	g. Citizen of V		/1
rai	5602 Vancouver C				20733			U.S.A	• e - American	to fine
by Funeral	11. Maritel Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Yeer or Detes:		If Yes, sp	ecify Cuben	, Mexican, Puert	pecify Yes or No- o Rican, etc.)		k, White, etc	С.
ed l	15. Decedent's E (Specify only highest gra	ducetion	16e. I	Decedent's Us	uel Occupet	tion	king	6b. Kind of Bu	siness/Indu	stry
Completed	Elementery/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retired)	iring most of wor	Killy	Staffo	rd Li	ncoln
Son	12		Sa	ales Ma	nager			Merc	ury	
Be	17. Fether's Neme (First, Middle, Last	")				18. Mother's Nen	ne (First, Middle, M	eiden Sumem	ne)	
To	Gordon F. Ciss	se1				Veron	ica E.	Daly		
	19e. tnforment's Neme/Relationship ((Type, Print)	19b.	Mailing Addres	s (Street a	nd Number or Ru	ral Route Number,	City or Town,	Stete, Zip C	ode)
	Helen A. Cissel -	- Wife	560	02 Vanc	ouver	Court,	Churchto	n, Mar	yland	20733
	20e. Method of Disposition 1 \overline{\text{D}} Buriel 2 \overline{\text{Cremetion}} 3 \overline{\text{D}}	38	20b. Plece of cemetery	Disposition (No.	ome of other place)	Dete 2	0c. Location -	City or Town	n, State
	4 □ Donetion 5 □ Other (Special		Fort L	incoln	Cemet	erv	9/9/98	Brentw	ood, M	Maryland
	23a. Fart Letter the disease, or come shock, or heart failure. Lat only Immediate Cause (Final disease or condition resulting in death)	polications that caused the one cause on each line	depth. Do no	4739 tot enter the mo	's Fur Baltin	neral Ho nore Ave	nue, Hyat		A Ir	20781 Approximate of the real Between onset and Death
<u></u>	resulting in dealin)	D	ue to (or as a c	onsequenca of):					
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State Registrar THEODOLE M. K.C. ete filed (Month, Dey, Year) SEP 0 9 1998

111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signeture

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	1. Decedant's Nam	a (First, Middla, Last)			Certificate of	Douth	2. Data of Dea	Reg. No.	-	3. Time of Death
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now Street direct

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death SETEMBER 04, 1998 12:46 AM RANDOLPH CREASMAN 4b. City, Town, or Location of Death 4c. County of Daath 4a Facility Nama (If not institution, giva stragt and number) HOSPITAL CENTER WHEVER prince gerges CHEVERLY PRINCE GEORGES 8. Data of Birth (Month, Day, Year) 6. Sex Months Days 1 M 2 □ F 241-60-0954 57 Yrs. Sept 18, 1940 North Carolina Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits Yas 2 No Maryland Prince George's Landover Hills 10f. Zip Coda 10g. Citizan of What Country? 3823 64th Avenue #203 20784 USA 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married 1 Yas 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Bank Teller Private 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) McKinley Brock Mary Creasman 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Ella Creasman/Wife 3823 64th Avenue #203, Landover Hills, MD 20784 of Disposition (Nama of Data 20c. Location - City or Town, State 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from State Arlington National Cem. 9/11/98 Arlington, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility J. B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Daath HYPERTENSIVE ARTERIOSCUEROTIC CARDIOVASCULAR PISTASE Dua to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disaasa or Injury that initiated avants Dua to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to 24a. Was an autopsy performad? completion of causa of death? 25. Was cesa rafarred to madicel examinar?
1 D Yas 2 No 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 VER/Outpatient 3□ DOA 1 Inpatiant 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 ☐ Yas 2 ☐ No 6 Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Madical Examiner: On the basts of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and mannar stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

the Merylend 28a-f show r than "natural", or items 23a or 28a-f shorter Medical Examiner must be notified at death within 72 hours efter Hyglene. permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event bûce.

Physician

/Medical

Examiner

10a. Stata

10e. Street and Number

12th

Immediata Causa (Final disaasa or condition resulting in death)

rasulting in death) Last

27. Manper of Death

1 Natural

3 ☐ Sulcida

29a. Certifier

4 Homicide

(Check only one)

11. Marital Status

Directo

Funeral

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Funeral

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Physician /Medical Examiner

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Physician/Medical Examiner

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31. Data filad (Month, Day, Yaar) SEP 0 9 1998

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32 Registrar's Signatura

death (Itam 23a) (Type, Print)

latad cause

3001 HOSPITAL

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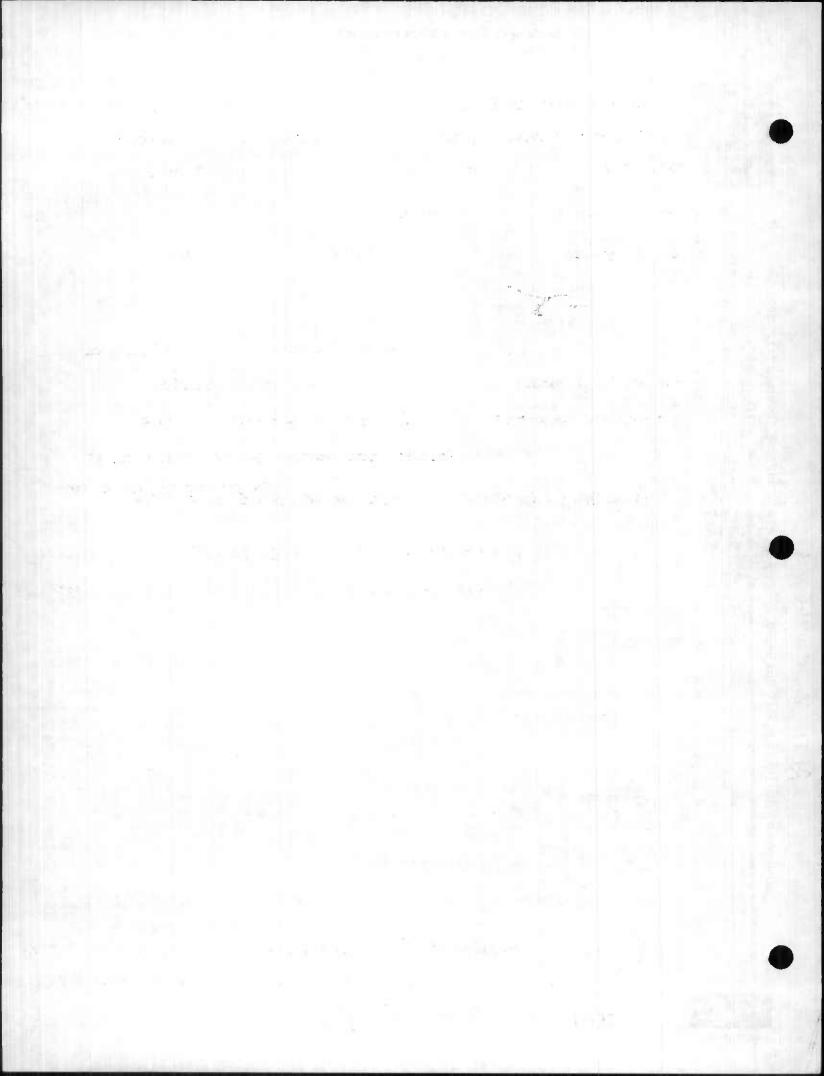
1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death SEPTEMBER 5,1998 **Physician** Ruth Zimmerman Chilcote 1140AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll Hours Min. 8. Date of Birth (Month, Day, Year) Feb 10 1906 5. Social Security Number 220–30–2572 If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 20 F 92 Yrs. MD Director Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 end 2 should be filed within 72 hours efter death with the Meryla ment of Health end Mentel Hygiene. Intit if Item 27 is marked other than "naturel", or frems 23a or 28a-f show mit; if Item 27 is marked other than "naturel", or frems Eas or 28a-f show mit; if Item 27 is marked other than 10 and 11 act. Md Carroll Sykesville 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5316 Wendy Road 21784 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify white by 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) medical secretary health care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles F. Zimmerman Fredricka DeSchaefer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Barbara Ryan (daughter) 5316 Wendy Rd. Sykesville, MD 21784 20b. Place of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1 Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lorraine Park Cemetery 9-9-98 Baltimore, MD Injury 22. Name and Address of Facility 21. Signeture of Funeral Service Licenses Haight Funeral Home & Chapel Paige Haught Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) CENOBROVASCULAR ACCIDENT /Medical Zweeck(**Examiner** Due to (or as a consequenca of): CONGETURE HEART FAILURE Physician/Medical Examiner week physician and the buriel-trensit The law requires that the deeth certificete be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by HYPERTENSION þ 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 Yas 2 No certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of Certification: After 1 or Attending 1 Natural 5 Pending investigation s effer death.

I Director: Aff
I h by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C completely filled edical 29a. Certifier 1 🗹 Cartifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number CANNOLL COUNTY Central HOSPITAC State

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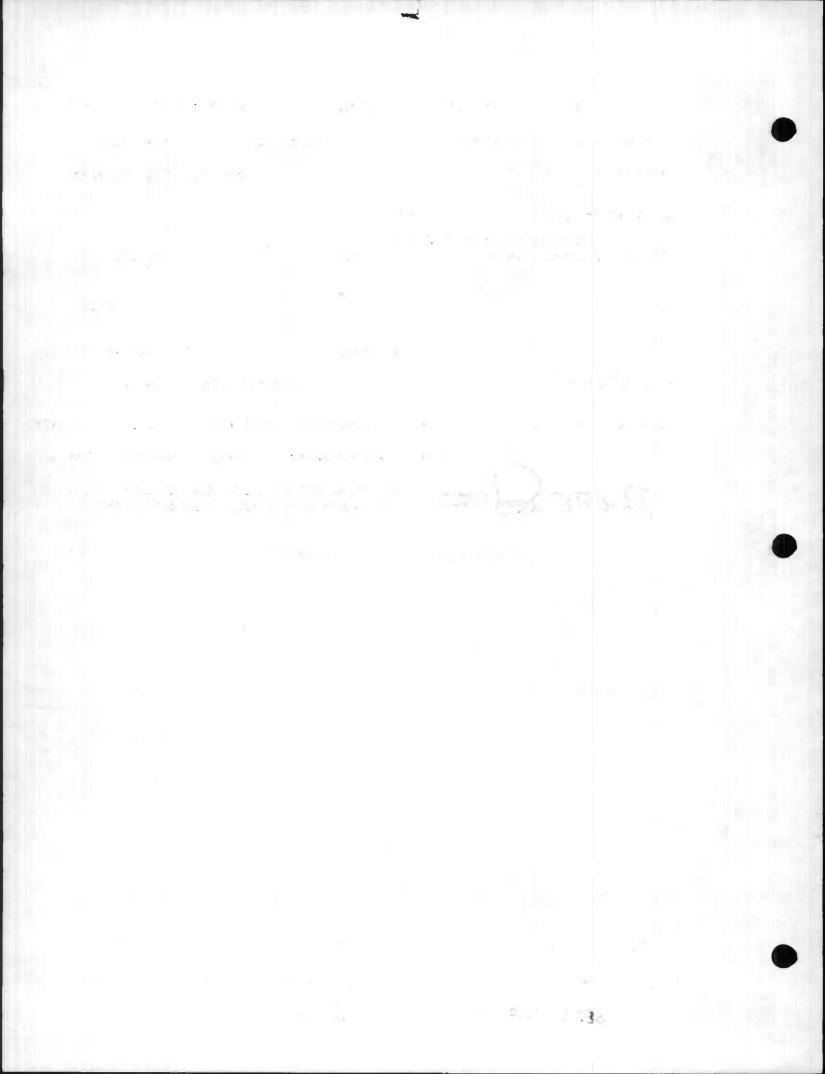
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State of Maryland / Department of Health and Mental Hygiene

			(Certificat	e of	Death	,	Reg. No.	1 2	9311
	1. Decedant'a Name (First, Middle, Last)						2. Date of Dea	ith		3. Time of Death
Physician	Ethe1	Virginia		Cli:	ne		Septemb	er 10 19	Yaar 998	4:20 AM
/Medical Examiner	4a Facility Name (If not institution, give s	treet and number)				4b. City, Town, or		-	of Death	
	Frederick Memoria	1 Hospital				Frederic	k	Frede	erick	ξ.
Funeral	5. Social Sacurity Number 6. Sex	7. Aga (In y	rs. last birth	day) If Under	1 Year Days	If Under 24 Hrs Hours Min.		h v. Year)	9. Birthp	placa (State or Foreign
Director	217-18-8211	M 201F 7	4 Yr	S.				, 1924		
and *	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town	or Location					1	Od. Inside City Limits
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vith the Mar	10e. Street and Number Homewoo	d Potironon	+ Cont	10f. Zig	Code			10g. Citizen of W	/hat Coun	ntry?
3ª or	31 West Patrick		t Cent		1701			U.S.	۸	
offer death virtues 23e	11. Maritai Status	2. Was Decedent Ever in						as or No- 14. Race - American Indian,		
ore, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Hem 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exercications be notified at To Be Completed by Funeral Director	1 ☐ Naver Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates:		1 Yes		Specify:	to rican, etc.)	Specify.		
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other tr	Eugenia Ropp (POA 20a. Method of Disposition		b. Place of E	Disposition (Ne	me of		al Pike,	Myersvi 20c. Location -		MD 21773
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Baltimol pemit. Pages Department of Important: If it any Injury or o	4 □ Donation 5 □ Other (Specify) 21. Signalure of Funaral Service License		ounc c	22. Name a		- 1	3/14/30	riedeli	LCK,	Maryland
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	resulting in death)			nsequence of)					1	
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68760, fificate be executed g physician and as the burial-transit fedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a co	nsequence of)					8	
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death death a after a for for sicial	Part II. Other algnificant conditions con	tributing to death but not	23b. Did tobacco use contributs to the cause of death							
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og Ph ig Ph naral	27. Manner of Deeth 1 Netural 5 ☐ Pending	28e. Date of Injury (Month, Day Year	28b. Tir	ne of	28c. Inju	y at rk?	28d. Describe	now injury occurr	ed	
or: Af tha fu	2 Accident investigation			M		Yes 2□No				
DIVISION OF VITAL Heel To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this cartificate has complately filled in by the funeral director, page 2 Medical Certification: To Be Comp	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, fam ecify)	n, street, factor	y, office		28f. Location (: City or To		er or Rure	al Route Number,
he Hospit in 24 houn he Funera plataly fill edical		Ician: To the best of my er: On the basis of exam and manner stated.								
To the Comp	29b. Signature and litle of certifier			29	c. Licens	se number		29d. Date signed	d (Month,	Day, Year)
. 37-0	Mil Waran	_ kmo			DA	7611		9-10-	98	
	30. Name and address of person who co	mpleted cause of death (Item 23a) (T	ype, Print)						
	Niew WARANGERM	MD 147	5 TA	WEY A	NR	#204 F	MEMICIC	MO	217	20
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrar's Si	-	6	1					

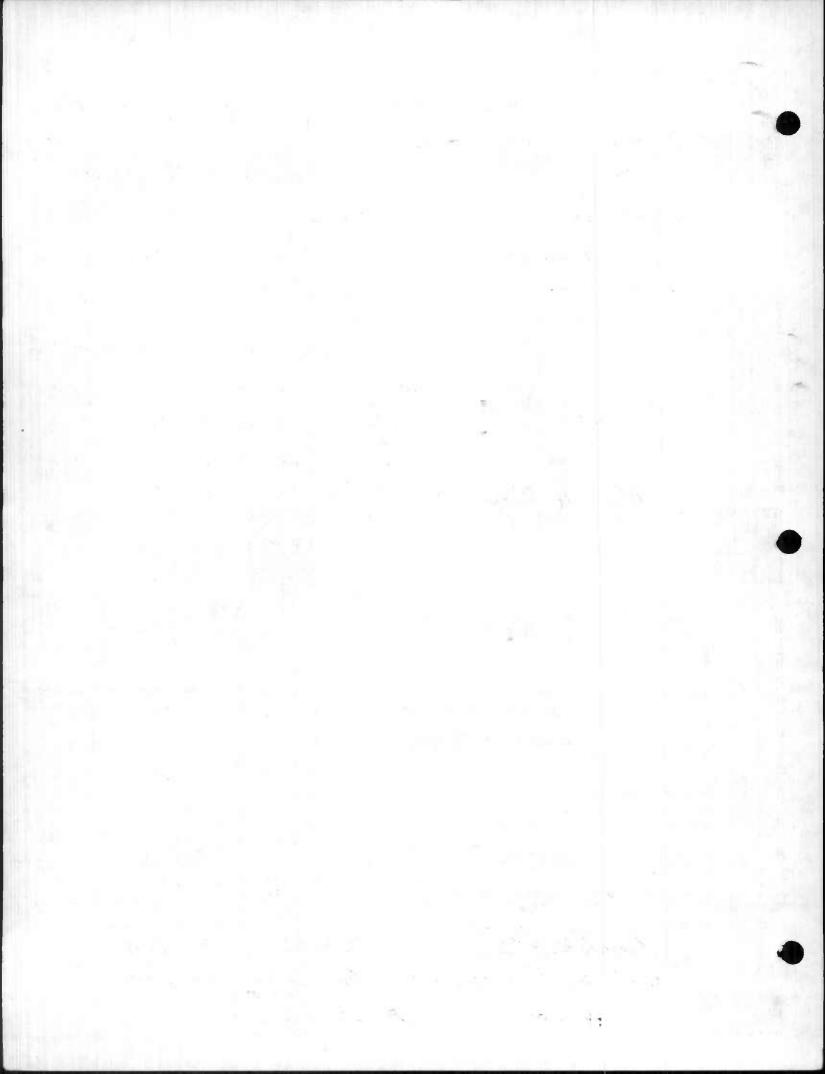
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Elizabeth Ann CULLEN GOT /Medical Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner PEATON SPECIALTY DAltimore HOSPITAL & Hone Hours Min. 8. Date of Birth (Month, Day, May 2, 5. Social Security Number if Under 1 Year Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Deys 43 Director 215-66-9342 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show items 23a or 28a-f short ner mant be notified at Director 1 Yes 2 No Maryland Frederick Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5107 Valley Pine Court 21703 U.S.A. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. "natural", or item 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 M Married 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Peges 1 and 2 should be filed with nent of Health end Mental Hygiene. Administrative Assistant Marriott International 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be WHITELAW VAN WYCK Hamilton Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest T. Cullen, III, Husband 5107 Valley Pine Court, Frederick, MD 21703 27 other altimore, or other 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 Donetion 5 Other (Specify) St. Philip's Episcopal Cemetery, Sept. 14, 1998 Quantico, Maryland 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, M00703 21701 23e. Pert1. Enter the disease, or complications the deuth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heer failure. List only one cause of each line. Approximete Interval Between Onset end Death **Physician** /Medical immediate Cause (Final DMOS disease or condition resulting in deeth) **Examiner** To the state of th Due to (or es a consequence of). 10 mos. 1 recember ractives The law requires that the death certificete be executed Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting In death) Lest Box 68760, Omos Physician/Medicai the P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the causa of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, þ Completed Dabety Mellitus. 24e. Was en eutopsy performed? 24b. Were eutopsy findings evailable prior to completion of cause of death? hes 1 Tes 2000 1 ☐ Yes 2 ☑ No certificate Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No spital or Attending Physi-nours efter deeth. nerel Director: After this r y filled in by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural subject ding 1 Yes 2 No 11 NEWENT 1340 MK 2 Accident attenuel 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) STATE Route 760 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide roodwar To the Hospital of within 24 hours of To the Funeral D completely filled in Sarasota Florida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the ceuse(s) and menner as steled.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end manner stated. Medicai 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 30. Hame and address of person who completed cause of deeth (Item 23e) (Type, Print). 1 alex 31. Dete flied (Month, Day, Year) 32. Registrar's Signature State Registrar



Box 68760. P.O. Records. of Vital Division

the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed or Attending Physician: illed in by the funeral 24 hours efter death.

Funeral Director: A Hospital To the Hospi within 24 hou To the Funer completely fil

Medical

State

Registrar

29a. Certifler

29b. Signature and title

September 9, 1998 30. Name and describes of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller, M.D. 4 Culwell Drive, Mount Airy, Maryland 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture SEP 0 9 1990

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

wilner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29d. Dete signed (Month, Dey, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, La.	St)				2. Date of De Month	ath Day	Year 3. Time of Dea				
Physician /Medical	LLOYD H.	CARMINE	, JR.			augu	st 311	1998 1513				
Examiner	4a Facility Name (II not institution, give				4b. City, Town, or L		4c. County	of Death				
	PENINSULA REGION			W11-3-40	SALISI			ICOMICO				
Funeral Director	5. Social Security Number 6. S 215–05–5413 1 Usual Residance of Decedent	Sex 7. Age	80 Yrs	Months Day		8. Date of Birt (Month, Da September	th 19. Year) 12. 1917	9. Birthplace (State or Fo Country) Maryland				
Bu .	10a. State 10b. County		10c. City, Town o					10d. Inside City Li				
25e-f sh notified.	Maryland Somer	set		Crisfield				1 ⊠ Yes 2 □				
iner matte notified funeral Director	10e. Street and Number 305 W. Main St.			10f. Zip Code	21817		10g. Citizen of W					
Exan by	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Examped Forcas? 1 Yes 2 Yes, Giva Year or Dates: 9	/2//1	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		pecify Yes or No Rican, atc.)	s or No- ltc.) 14. Race - American Ind Black, White, etc. Specify: White					
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Be week	17. Fathers Name (First, Middle, Last)				18. Mother's Nam		, Maiden Sumam	a)				
Men arke	Lloyd H. Carmine				Myrt	le Byrd						
2 2 2	19a. Informant's Name/Relationship (Mailing Address (Street				Stata, Zip Code)				
Dar t	Carolyn H. Carmin	ne (Wife)		5 W. Main	St Cris							
ment of Health ant: If Hern 27 ury or other to	20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of cemetary and complete place) American Legion Cemetary 9/3/98 20c. Location - City or Town, State cemetary 9/3/98 Crisfield, MD											
Depart Import any in	21. Signature of Fine Signature of Facility 22. Nama end Addrass of Facility Bradshaw & Sons Funeral Home 306 W. Main St Crisfield, MD 21817											
	Robert H. Brac	dshaw, Jr.	he death. Do not	306 W. Ma	ain St C	risfiel	d, MD	21817 Approximate				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Septem Gev 9 1998 4b. City, Town, or Location of Death 4c. County of Death 1330 Beulah Mae Cannon 4a Facility Name (If not institution, give street end number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days 1□M 2KIF Months 218-24-4549 MD Usual Residence of Decede 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ₩ Yes 2 No MD Somerset Princess. Anne 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11840 N. Beachwood St. 21853 .S 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 XNo If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Domestic House Wife 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles A. Nixon Mary Nixon 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2185319a. Informant's Name/Reletionship (Type, Print) George Cephas - Son 11840 N. Beachwood St. Princess Anne, MD 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 Other (Specify) Carmel Cemetery 9-14-98 PrincessAnne, MD 22. Name and Address of Fecility Anthony E. Ward Funeral Home 21. Signature of Funeral Service Licensee 21853 30639 Hampden Ave. Princess MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete tritervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) enios dero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be nent of Health and Mental

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Completed

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72 hours after death with the Maryland

Examiner physician and the burial-transit for use as funeral n 24 hours after death the Funeral Director: A plately filled in by the f

The law requires that the death certificate be executed

Box 68760.

P.O.

Records.

Division of Vital Attanding Physician:

100

death.

To the Hosp within 24 hos To the Fune completely fi

6 Hospital Physician/Medicai þ Completed Be Certification: To 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No

6 ☐ Could not be

1 Inpatient 5 Pending investigation

28a. Dete of Injury (Month, Day Year) 28b. Time of

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated.

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a. Wes an autopsy performed?

1 Yes

26. Place of Deeth (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

24b. Were sutopsy findings available prior to

completion of cause of death?

1 ☐ Yes 2 ☐ No

29b. Signature shd title of certifier

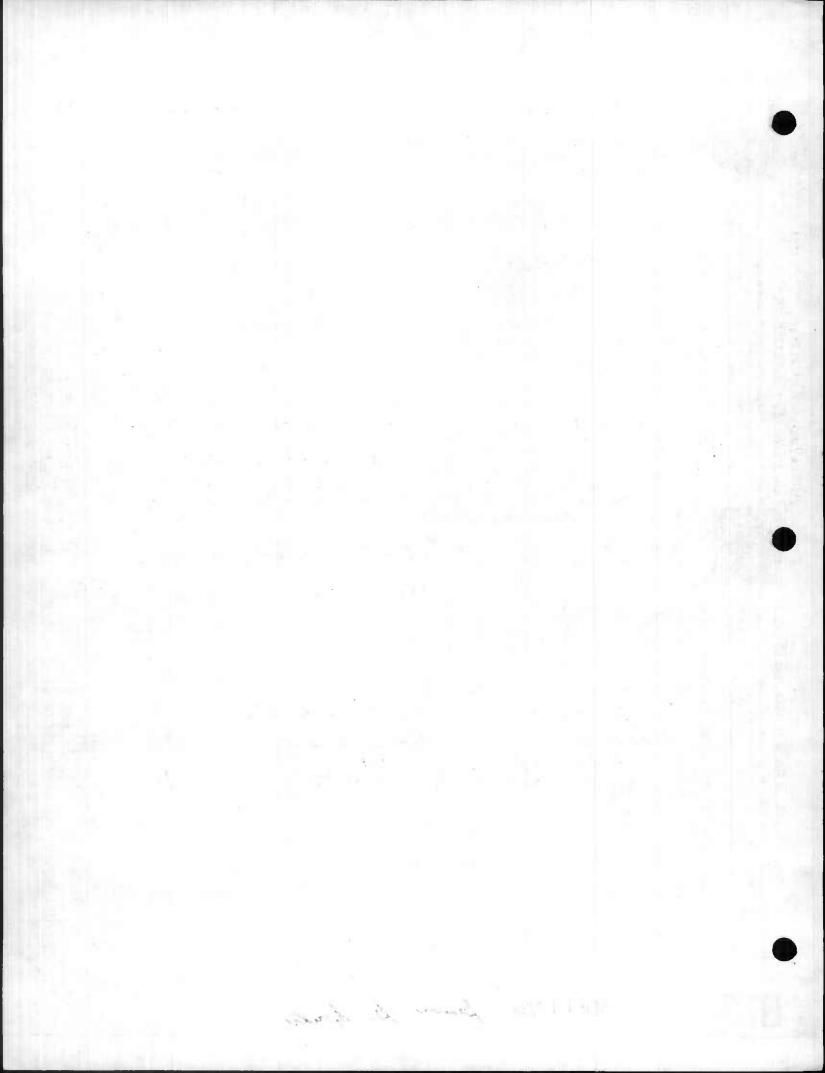
29c. License number

29d. Date signed (Month, Day, Year)

th (Item 23a) (Type, Print) Etre cta

er's Signature

State Registrar



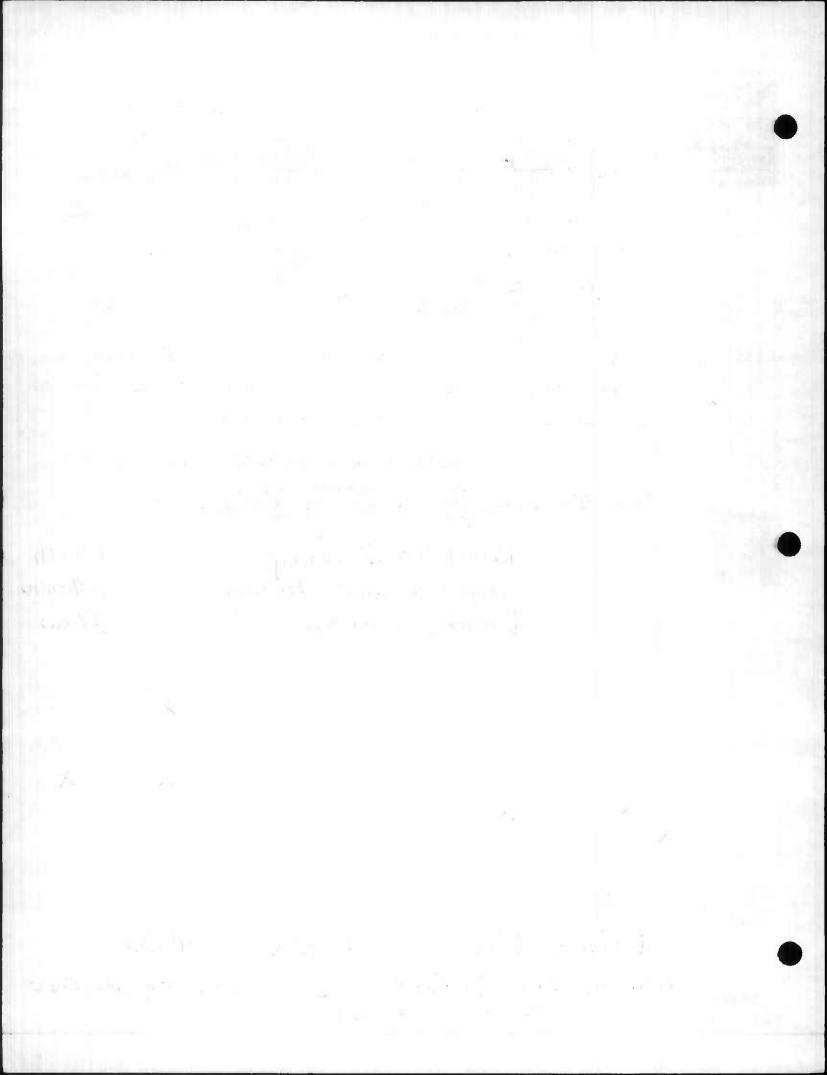
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death c 11 1998 Month **Physician** George Edward 0830 September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester 206 Choptank Ave. Cambridge 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Dey, Year) March 2 1924 7. Age (In yrs. last birthday) **Funeral** 20 F Months Deys Hours 74 Yrs. 218-14-4124 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Itam 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits TAYOS 2 No Director Cambridge MD Dorchester 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 U.S.A. 206 Choptank Ave. deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? 154 × 2 □ No 167 es, Give Yeer or Dates: 1942–48 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 72 hours efter 1 ☐ Never Married Married Baltimore, Maryland 21215-0020 1 Yes 2000 Specify. þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than any Injury or other traumath. Elementary/Secondary (0-12) College (1-4or 5+) construction union 11 carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Warfield Whitmore Dean Sadie Elizabeth Ray 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ethel B. Dean - wife 206 Choptank Ave. Cambridge MD 21613 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Durial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) Maryland Veterans Cemetery 9/14 Hurlock, Maryland 21. Signature of Emperal Service Licensee 22. Name end Address of Facility Thomas Funeral Home P.A. 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner feather bunal-transit pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest P.O. Box 68760. physician that the death certificete be Physician/Medical the Due to (or es a consequence of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes No 3 Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed peeu pege 2 s 1 Yes No this certificate To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Yeer) Medical Certification: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date sighed (Month, Dey, Year) completed cause of death (Item 23e) (Type, Print) Cambridge Ml 21613 State

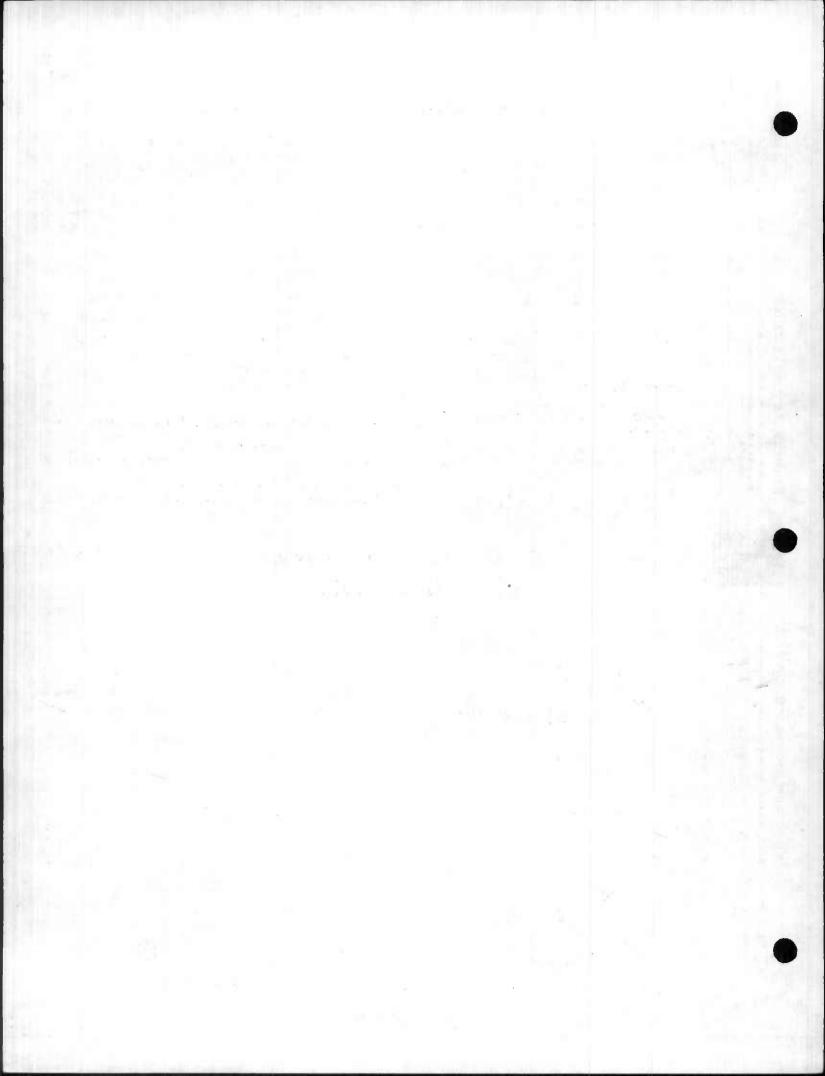
Registrar



State of Maryland / Department of Health and Mental Hygiene

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		William Renzulli			urton R	oad	, Elkto	n, Mary	land	21921			
	State	31. Dete filed (Month, Day, Year)	32. Registrer's	Signeture	las v	,							
	Registrar	SER 1 0 1998	Land.	12.	Sporks	1							

DHMH 16 Rev 6/95



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 December Name (Cont. Middle, Lo.	net l	Ce	ertificate of	Death		Reg. No.	293 8	
cian	Decedent's Nama (First, Middla, Last					2. Data of Dea Month	Day	Year	
lical	ROSE MARIE	DUGAN	34.7			SEPT	04 1	998 1617	
iner	4a Facility Nama (If not Institution, give			2000	4b. City, Town, or L	ocalion of Death			
	Fallston General	-		al Billadas d Man	Fallston		Hari		
r	216-32-1046	THE APPE	(In yrs. last birthda) 52 Yrs.	Months Days		8. Data of Birt (Month, Day Apr. 1,	r, Year)	9. Birthplaca (Stata or For Country) Maryland	
	Usual Residence of Decedent 10a. Stata 10b. County		IOc. City, Town or	Location				10d. Inside City Lin	
oto	Maryland Harfo	ord	Joppa					1 ☐ Yes 200	
Dire	10e. Street and Number			10f, Zip Code			10g. Citizen of W	hat Country?	
	800 Foxwell Road	1		2:	1085		USA	USA	
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yas 2 No If Yes, Give Yaar or Datas:		. Wes Decedent of If Yas, specify Cul 1 ☐ Yas 2 ☑ No	Hispanic Origin? (Spoan, Mexican, Puarto Specify:	pecify Yas or No- Rican, atc.)	No- 14. Race - American Indian, Black, White, atc. Specify: White		
B	15. Decedent's Ed	lucation	16a, Dec	edent's Usual Occu	pation		16b. Kind of Bus		
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	12		Sur	ervisor	18. Mothar's Nam	a /First Middle		overnment	
Be	17. Father's Nama (First, Middle, Last)		ioniae			_		nuba	
2	William Micha		iewicz		Laura	Helen			
	19a. Informant's Neme/Reletionship (7				t and Number or Ru				
	Richard D. Dugan -	- Husband			Road, Jop			1085	
	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Stata	cematary, cr	position (Nama of amatory or other pla	109)	Data	20c. Location - 0	City or Town, Stala	
	4 ☐ Donation 5 ☐ Other (Specify		Holy Ros	sary's Cer	metery !	9/8/98	Baltimo	re, Maryland	
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cal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. me	ue to (or as a cons	equence of):	care	rla	na	legea	
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DHMH 16 Rev 6/95

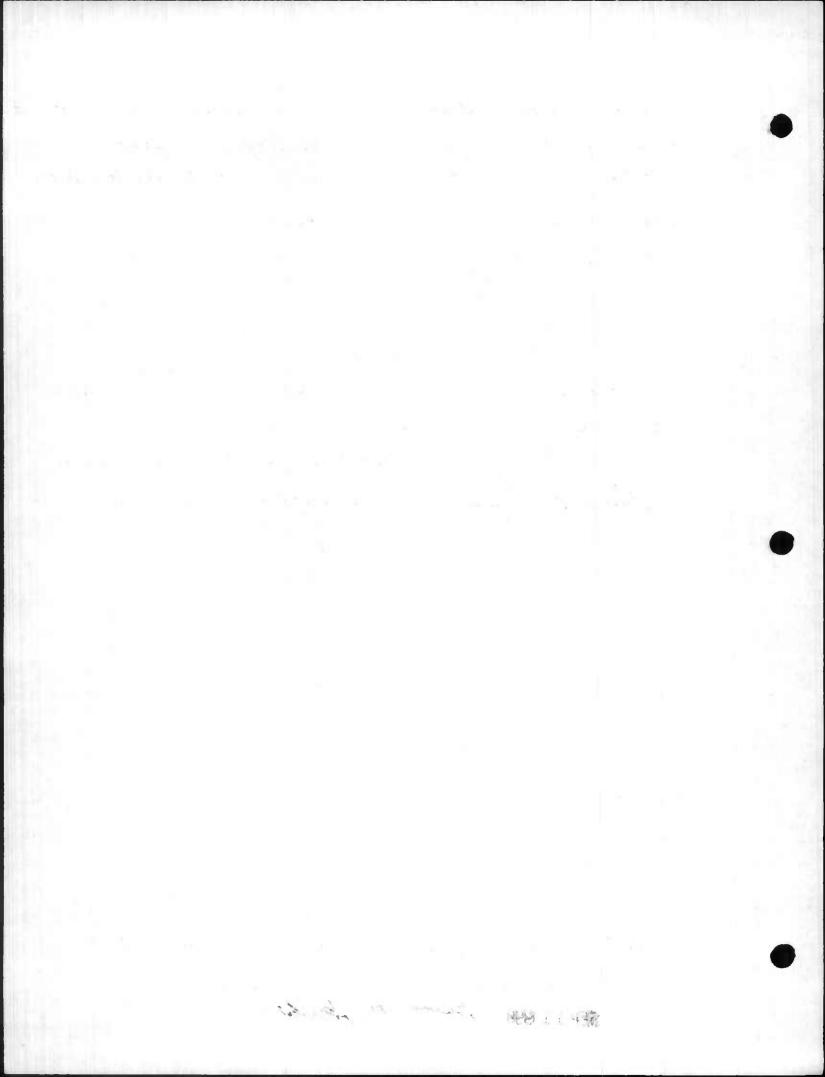
DUGAN, Rase MARIE

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State of Maryland / Department of Health and Mental Hygiene

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		Karl L. Donhaus	ser / son		same	e as # '	10 above				
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houi	Completed							24a. Wes e perfor	med?	available prior completion of	to
has t	ig.				3					of death?	
certificate ha	ပိ							1□ Y	es 2 🗆 No	1 ☐ Yes 2 ☐] No
tor	Be	25. Was case referred to medical exeminer?					26. Piece of Dee	th (Check only or	ne)		
2 8	၉	1 Yes 2 No	Hospitel: 1 Inpe	tlent 2 🗆	ER/Outpetient	3LI DUA		ome 5 Resid	ence 6 Other	r (Specify)	
0 0	5	27. Menner of Death 1 ☐Naturel 5 ☐ Pending	28e. Dete of In (Month, I	jury De <i>y Year)</i>	28b. Time of tnjury	28c. Inju	ury et ork?	28d. Describe h	ow injury occurre	od	
0 0		2 Accident Investiga	ation				Yes 2□No				
0,0	at			njury - At ho		et, fectory, office		28f. Location (S City or Town		r or Rural Route Nur	nber,
O S	tificati	3 ☐ Suicide 6 ☐ Could no determin			,						
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24 hours after death. Funeral Director: After this stely filled in by the funeral di	edicai	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could no determin 29e. Certifier 1 ☐ Certifying	building,	of examinet	viedge, deeth ion and/or inve	occurred at the testigetion, in my	time, dete end plece, opinion, deeth occur	end due to the c red et the time, o	ause(s) end man ate end plece, er	ner as stated. nd due to the ceuse(s)
24 hours after death. Funeral Director: After this stely filled in by the funeral di	ledical	3 Suicide 4 Homicide 4 Homicide 6 Could no determin	Physician: To the best	of examinet	wledge, deeth ion and/or inve	29c. Licen	opinion, deeth occur nse number	red et the time, o	ate end plece, er	nner as stated. Ind due to the ceuse((Month, Dey, Year)	s)
ze nours arrer deaun. Funeral Director: After this stely filled in by the funeral di	ledical	3 Suicide 4 Homicide 6 Could no determin 29e. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best	of examinet	wiedge, deeth ion and/or inve	29c. Licen	opinion, deeth occur	red et the time, o	ate end plece, er	nd due to the ceuse(s)
Funeral Director: After this stely filled in by the funeral di	Medicai	3 Suicide 4 Homicide 6 Could no determin 29e. Certifier (Check only one) 1 Certifying 2 Medical Ex	building, Physician: To the besaminer: On the basis end menner	of examinet steted.	dem.	29c. Licer	opinion, deeth occur nse number	red et the time, o	ate end plece, er	nd due to the ceuse(s)
0,0	Medicai	3 Suicide 4 Homicide 29e. Certifier (Check only and one) 29b. Signature end title of certifier 30. Name and eddress of person w	building, Physician: To the besaminer: On the basis end menner	of examinet steted.	dem.	29c. Licer	opinion, deeth occur ase number	red et the time, o	ate end plece, er	nd due to the ceuse(s)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death September 6, 1998 **Physician** Lawrence 3:20 P.M. Dare /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Larkin Chase Nursing Home Bowie Prince George's 7. Aga (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 F 6. Dete of Birth (Month, Dey, Ye April 1, 9. Birthplaca (Stete or Foreign Funerai Days Hours 73 Maryland 219-30-2793 Yrs. Director Usuel Residence of Deceden the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylar Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinet must be notified at once. 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel Harwood 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 20776 1503 J USA Flanders Lane Funerai 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Give Yaar or Dates: 11. Marital Status 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dare Mary Eliza Dare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Brookins/Daughter Flanders Lane Harwood, MD 20776 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 9/10/98 4 Donetion 5 Other (Specify) Moses Cemetery Lothian, MD 21. Signature of Funarai Sarvice Licenses 22. Nama and Addrass of Facility Sewell Funeral Home Mady 1451 Dares Beach Rd. Prince Frederick, MD 20678 9. 23a. Part 1. Enter trie disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Deeth Physician Metas Patric /Medical Immediate Cause (Final ardinama diseese or condition resulting in death) Years Examiner Due to (or as a consequence ot): Physician/Medical Examiner The lew requires that the death certificate be executed attending physician and for use es the buriel-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) P.O. Box 68760. Dua to (or as a consequence of): resulting in death) Last ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 2 24b. Were autopsy findings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? After this certificate has funeral director, page 2 1 Yes 2√No 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☑ No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 1 Neturel 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) efter 4 ☐ Homicide within 24 hours eff To the Funeral Di completely filled in To the Hospital 29a. Certifier 1 detrifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated.

2 Madicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, end dua to the cause(s) Medicai and mannar stated. 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 45660 is of person who completed cause of death (Item 23a) (Type, Print) V, Bowie LLAN 0 00 31. Date filed Whenth, Day Year 98 32 Registrade Signature

State Registrar Division of Vital Records, P.O. Box 68760.

31. Dete filed (Month, Dey, Yeer, SEP 0 9 1998

William Behrens, M.D.

2448 Holly Avenue #100, Annapolis, Maryland 21401 32. Registrer's Signeture Sports

30. Neme end eddress of person who complated cause of deeth (Item 23a) (Type, Print)

September 8, 1998

Registrar

State

			Plea			nt In Black aryland / D	eparl		Health and	-		98	e. 2	9323
		1. Decedent's Nam	e (First, Mido	le, Last)						2. Date of D	eeth			3. Time of Deeth
Physi /Med	dical	Marga 4a Facility Name (Christin					4b City Town	Month Septem				8:11 pm
Exam	iner													,
	1	5. Social Security N		6. Sex										ce (Stete or Foreig y)
Funera Directo		579-28-30 Usual Residence o		1□ M 2ŌX			rs.	Months Days	Hours M	in. (Month, Dec. 2	99, Year)	905	Count Irel	
land		10a. Stete	10b. County	/		10c. City, Town	or Local	tion					10	d. inside City Limits
Mery	tor	Maryland	Princ	e Georg	010	Hyatt	ewi	110						1∭ Yes 2☐No
the root	Director	10e. Street and Nu		c dedig	C 5	nyact	-5VI.	10f. Zip Code		10g. Citizen of What Co			y?	
filled within 72 hours eiter death with the Meryland Hygiene then "hatural", or Items 23s or 28s-f show ent, the Medical Examinat must be notified at	O O	6117 418	st Aver	nue				207		U.S.A.				
deat rms 2	Funeral	11. Maritai Status		12. Wes I	Decedent d Forces?	Ever in U,S.	13. Wa		(Specify Yes or N					
or he		1 Never Marr	ied 2□ Mai	ried 1 □ Y	es 2 XII				Decedent of Hispanic Origin? (Specify Yes or specify Cuban, Mexican, Puerto Rican, etc.				White, e	IC.
ours ref.	1 by	3 🖾 Widowed	4 Divorce	Year	If Yes, Give Year or Dates:									te
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filed within Hygiene, other then		17 Father's Name		(act)		r	iomei	naker	18 Mother's N	lame (First, Middl			e	
d 2 should be filed th and Mental Hygi 7 is marked other traumatic event, t	Be	17. Father's Name (First, Middle, Last) John O'Brian												
2 should be and Mental is marked o	70	John O'Brian Catherine Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, and Number or Rural Route Number								ate Zin (Codel			
1 end 2 s Heelth an em 27 is rither traus		Margaret								attsvill				20782
beth certificate be executed W/ Why attending physicien and for use as the burial-transit region	il 🗀	23a. Pert I/ Enter to shock, or head immediate Cause disease or condition resulting in deeth) Sequentially list colif any, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death)	(Final on on officers of the conditions, on officers of the conditions of the condit	a. Ca	New 100-	y tul due to (or es e co mov Due to (or as e co	The posseque conseque	and Fince of): Lince of): Lince of):	ing, such as card		attsvarrest,	<u>ille</u> ,		20781 Approximate interval Between Onset and Deeth
deeth certifi e attending od for use as	sician	Part ii. Othar signit	licant conditi	ons contributing	to death b	ut not resulting in	the unde	erlying cause gi	iven in Part i.	23b. Di	d tobacco	usa contri	bute to	the cause of death
es that the de igned by the ibe deteched	by Phys	Core	nam	Art	erz	Dise	as	2		1[1 Yes 2 No 3 Probably 4			ably 4 Unknow
aw requir	Completed b	Silent Myocardial Infarction 24a. Was en autopsy performed?									con	re autopsy findings leble prior to apletion of cause eath?		
	Co									10	Yes 2	No	1 🗆	Yas 2□ No
ician: The certificate rector, pag	Be	25. Was case refer examiner?		Hoenital:				Ot	her _	Deeth (Check only				
Phy this	on: To	1 ☐ Yes 2 数 27. Manner of Deat 1 数 Natural		28a. D	I Nonth, De	ry 28b. Ti		28c. Inju	4 □ Nursin ury at ork?	28d. Describ)
or Attending after death. Director: After in by the fune	Certification:	2 Accident 3 Sulcide	6 Could		lace of Ini	ury - At home, far	m street		Yes 2 No	28f. Location	(Street er	d Number	or Rurel	Route Number,
or Attending after death. Director: After d in by the fune	erti	4 🗆 Homicide	deterr	nined 200. b	uitding, et	c. (Specify)	111, 3(100)	, ractory, omco		City or T	own, Stete)		
To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edicai C	29a. Certifier (Check only one)		Examiner: On the		of my knowledge, f examination end								
ithin of the	Mec	29b. Signeture and	title of certific					29c. Licen	se number		29d. Da	te signed (/	Month, D	Dey, Year)
F ₹ ₩ 8			- 1	u Tu					6998			7-5		
6)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								-	10			
(6)		STEVE	NTE	E MI	D	3415 H		wilton	ST H	YATTS	VILLE	E, M	020	0782
	tate trar	31. Date filed (Mon	1h, Dey, Year 0 9 19		Registr	ar's Signature		porte						

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death SEPT. 08° **Physician EMMA** 1998 LOUISE DORSEY 7:20A M /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CITIZENS NURSING HOME FREDERICK FREDERICK 8. Dete of Birth (Month, Dey, Year) 13, 1909 If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 220-30-7720 1□ M 2☑ F 88 YES SEPT. Director MD. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiens.
Important: If itsm 27 is marked other than "natural", or items 23s or 28s-f show such injury or other traumatic avant, the Medical Examinat must be notified at page. 10d. Inside City Limits MD. FREDERICK FREDERICK Yes 2 No Director 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 194 WEST ALL SAINTS ST. 21701 U.S.A. Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck White atc 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: BLACK 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry PRIVATE FAMILIES Elementery/Segondary (0-12) College (1-4or 5+) DOMESTIC 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme)
HARRIETT ROBERTS B JAMES ROBERTS 2 19b_Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1796 HILLMEADE SQ. FREDERICK MD. 21702 19a. Informant's Neme/Relationship (Type, Print) AMBUSH EMMA 20b. Place of Disposition (Name of LIBERTY Permetory or other place)
ST. PETER CATH. CEM. 20c. Location - City or Town, State
LIBERTYTOWN, MD. 20a. Method of Disposition SEPT. 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
GARY L. ROLLINS FUNERAL HOME 21. Signature of Funeral Service Licenses 21701 110 WEST SOUTH ST. FREDERICK, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) Cartio Vasanla Desun /Medical Examiner Due to (or as a consequence of) Examiner attending physician and for use as the buriel-transit cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of) Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 6 1 Yee 2 10 3 □ Probably 4 □ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed cartificate has SELNO 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Yes 70 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred al or Attanding P s sftar death. I Diractor: Aftar t id in by the funan Certification: 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Dev. Year) an cause of death (Item 23a) (Type, Print) 21701 Kober mann MD 31. Date filed (Month. 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

306 8 8 4356

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Day 13,1998 Month **Physician** Frank Evans Ero September 1630 /Medical 4e. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester 5. Social Sacurity Number 6. Sex 12 M 2 □ F If Undar 1 Yeer | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) June 22, 1 Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min 214-07-7210 84 Yrs. Director 1914 Maryland Usuei Rasidance of Decedani 10a. Stata 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Expenser must be notified at 10d. Inside City Limits Maryland Dorchester tXYas 2□ No Director Cambridge 10e. Street and Numbar 10f. Zip Code 10g. Citizen of Whet Country? 911 Talisman Lane 21613 US 12. Wes Decedant Evar in U,S. Armed Forcas? tXXYes 2 □ No If Yes, Giva Yeer or Datas: WW Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Ricen, atc.) Raca - Amaricen Indian, Biack, Whita, atc. 72 hours efter 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ◯ No Specify: White by 3\ Widowed 4 □ Divorced WW II Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Hygiene. Coilega (1-4or 5+) Elamantary/Secondary (0-12) 11 Broker Real Estate other 1 17. Fathar's Nama (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: if Nem 27 Is markad oth any liqury or other traumatic event potes. 18. Mothar's Name (First, Middle, Maldan Sumama) Be Frank Joseph Ero Amy Evans 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Cynthia E. Bourquard Daughter 3113 Lynn Acres Road Virginia Beach, VA 23452 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Dopation 5 ☐ Othar (Specify) Dorchester Memorial Park 9/16/98 Cambridge, Maryland 21. Signature of Funaral Service Licensea 22. Nama and Address of Fecility Thomas Funeral Home, P.A. 1. Entar tha disaasa, or complications that ceusad tha daath. Do not antar the mode of dying, such es cardiac or respiratory arrestok, or heart feilure. List only one cause on each line. 700 Locust Street Cambridge, Maryland 21613 Approximata Intarval Batween Onsat and Death Physician Immediata Causa (Final disease or condition resulting in death) /Medical . Intracevebral hemorrhage 2 week/ Examiner Dua to (or as e consequance of): Examiner The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cousa (Disaasa or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): pue buriel-trar physician s the buriel P.O. Box 68760, Physician/Medical Dua to (or as e consequence of) for use as Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? Disease 3 Probably 4 Unknown tea/+ DIRELIONS Records, Completed by 24b. Wera autopsy findings available prior to complation of cause of daeth? 24e. Wes an eutopsy ibnilation performad 1 ☐ Yas 2 No 1 Yes 2/7 No Division of Vital tal or Attending Physician: The star death.

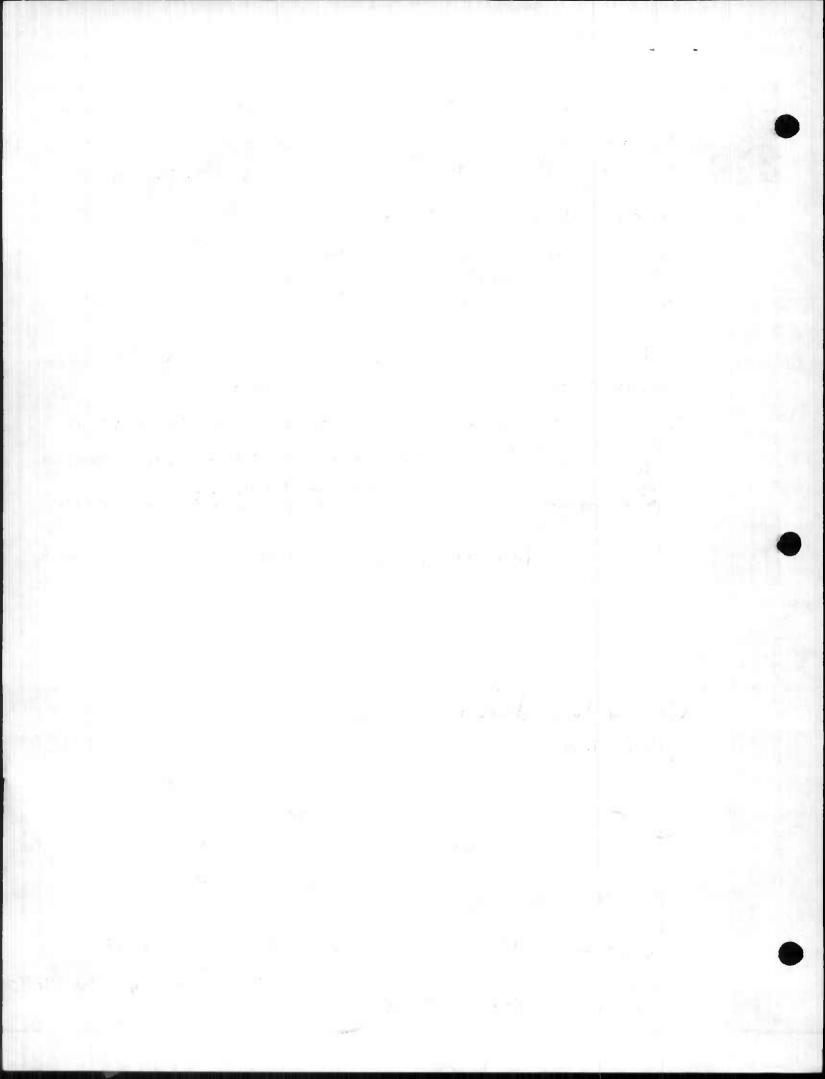
si Director: After this certificate in by the funerel director, pe 25. Was cesa refarrad to medicei axaminar? Be 26. Piaca of Daath (Check only ona) Hospitai: 1 Inpatiant 2 ER/Outpatiant 3 DOA Other: 4 Sing Homa 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28d. Dascribe how Injury occurred Certification: Maturel 5 Panding invastigation NIA 1 Yas NA 2 Accident NIA 6 Could not ba 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida To the Hospital o within 24 hours of To the Funeral DI completely filled in NIA 1 retifying Physician: To the best of my knowladga, daath occurred at tha time, data and piece, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) end menner stated. edical 29a. Cartifian (Check only one) 29b. Signetura and titla of certifier 29c. Licansa numbar 29d. Data signed (Month, Day, Year) D11284 9.14.98

State Registrar 31. Data filed (Month, Day, Yaar)
SEP 15 1998

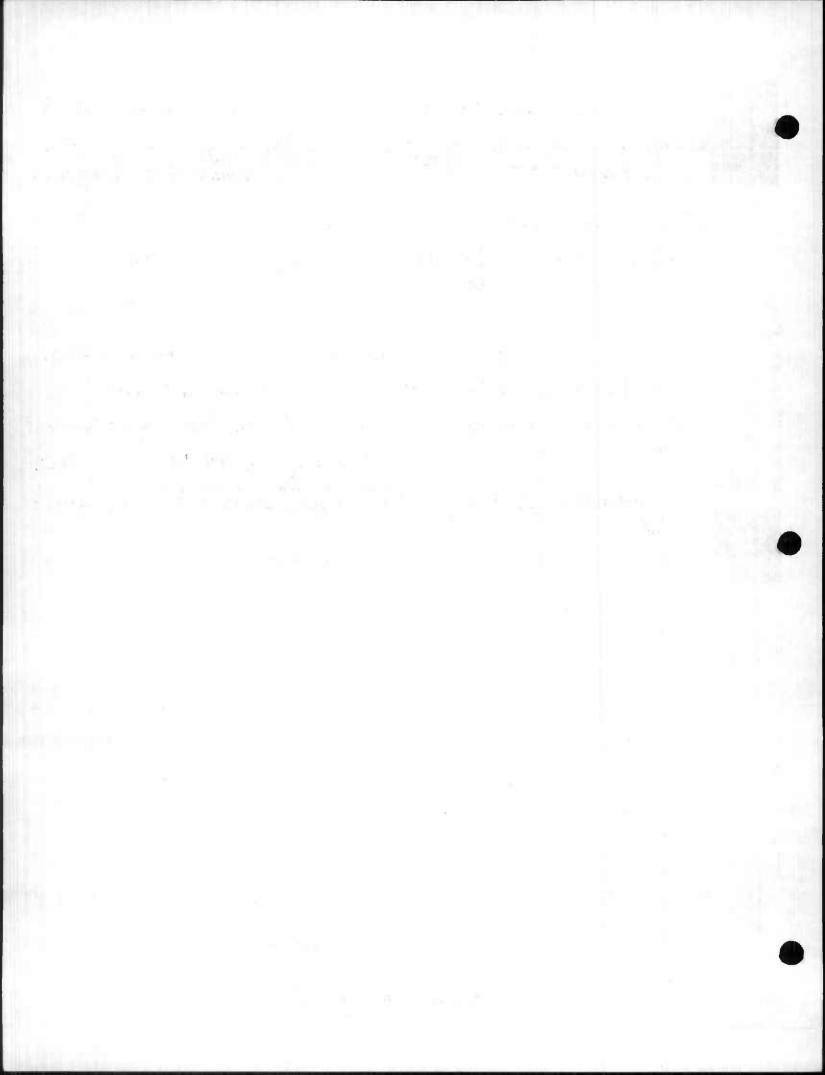
32. Registrar's Signature

30. Nama and addiess of person who completed cause of death (Itam 23a) (Type, Print)

400 Maryland Ave. Combridge 4D 21613

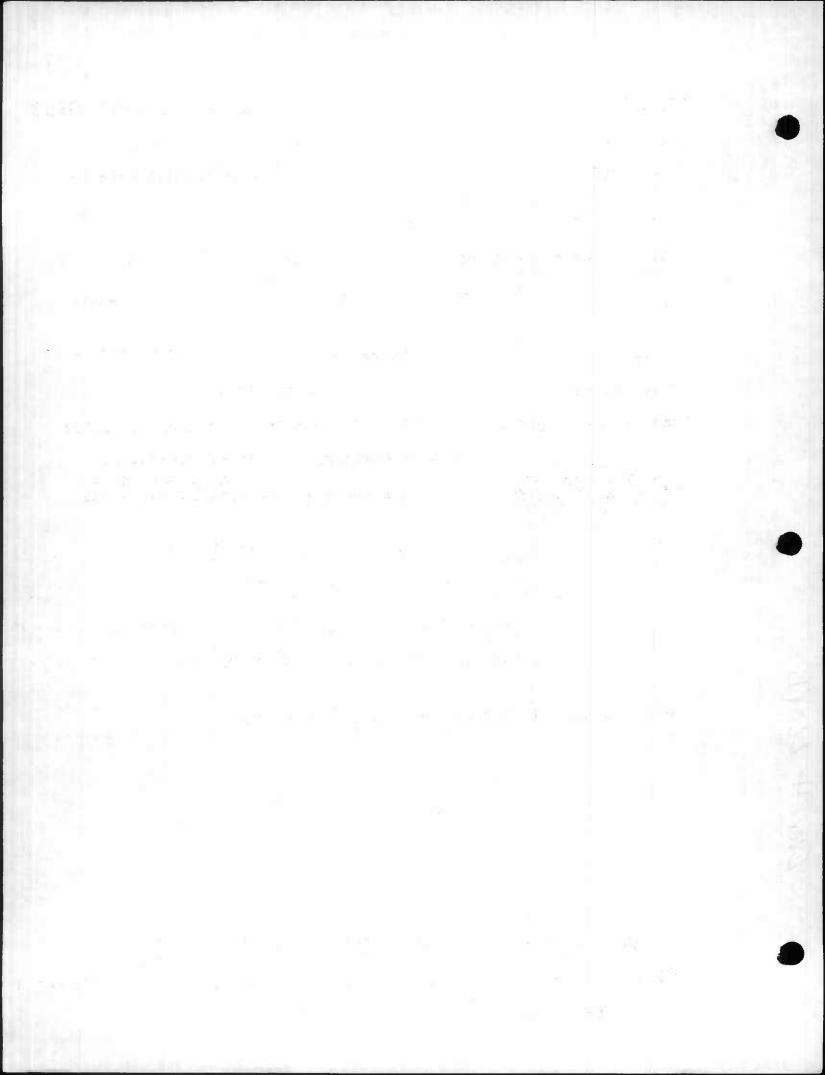


			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	29926
	Physici		" VOAL OR MILLET FAIRER CONT 12 10	fear 3. Time of Deeth
	/Medic Examin Funeral Director		Dorchester General Hospital Cambridge Dor	
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inaide City Limits 1 ☑ Yes 2 ☐ No
	or 28a	Directo	10e. Street and Number 10f. Zip Code 10g. Citizen of Wh	at Country?
	s 23a	rai	1001- Camelia Circle 21613	A
5-0020	72 hours after death with the Maryland natural', or items 23a or 28a-f show licel Example must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? In	American Indian, White, etc.
21215-0	within 72 ho me. then "neture the Medical is	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busi	ness/Industry
	filed within I Hygiene.	Be Co	Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme)	c School
Maryland	should be filed with and Mental Hygiene, is marked other than surratic event, trees	ToB	e Nathaniel Winston Pauline Bolli	NQ
	tealth dealth om 27 i		19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, St Dak leve Ennels 20b. Place of Disposition (Neme of camelory or other place) 20c. Location of Disposition (Neme of camelory or other place)	
Baltimore,	Page nent c ant: if		1 Dr Burial 2 Cremation 3 Removal from State 8 Cemetery, cremetory or other pleca) 4 Donation 5 Other (Specify) Rethel Cemetery 9/17/98 Cambra	
Balt	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home P. A.	MD, 2/6/3
	Physician /Medical		shick, or heart fallure. List only one cause on each line. Immediate Ceuse (Final disease or condition	Approximate Intervel Between Onset and Death
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Records,	aw requii ss been s 2 should	Completed I		24b. Were autopsy findings available prior to completion of cause of death?
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Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number City or Town, Stefe)	or Rural Route Number,
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	To the within To the	Me	≥ 29b. Signature aper tille of certifier 29d. Dete signed ((Month, Dey, Year)
			10 CO Cle mo D50804 9-15	-98
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Malkis, mi) 408 Byrn St. Cambridge MD 216	.12
	Sta Registr		31. Date filed (Month, Par Sar) 5 1998 32. Registres Signature 4.	



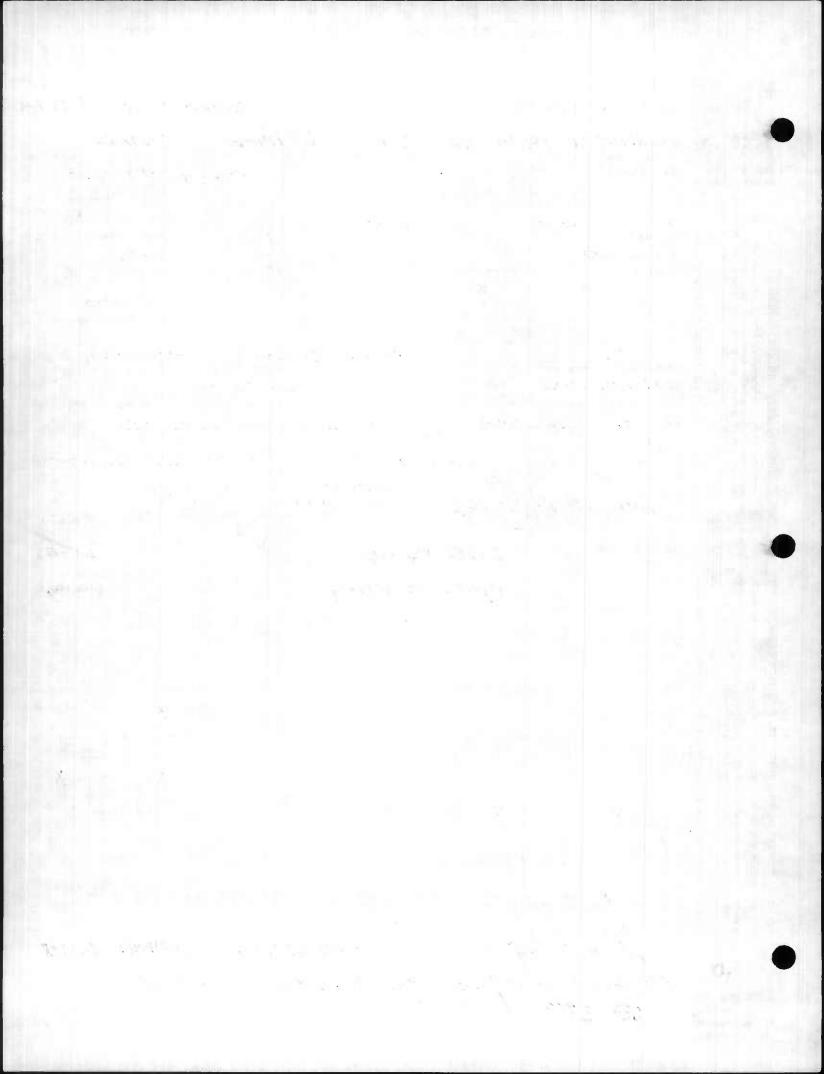
State of Maryland / Department of Health and Mental Hygiene

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/Medic		Lloyd Everett					Spotem	ber 10/99	18 083
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or 28a-f	irec	10e. Street end Number		Dire	10f. Zip Code			10g. Citizen of Whet	Country?
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Nems Der DS	Funeral Director	11. Marital Status	12. Wes Deceder Armed Forces		13. Was Decedent of If Yes, specify Cub		Specify Yes or No-		nerican Indien,
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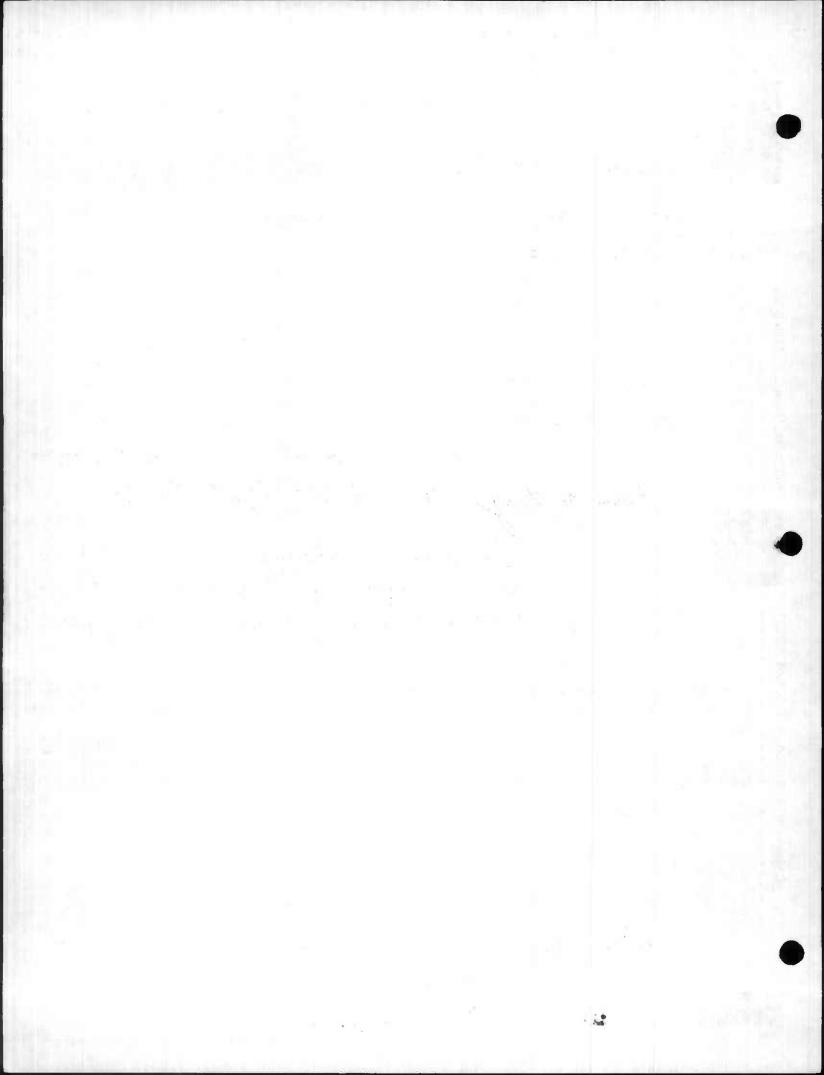
State of Maryland / Department of Health and Mental Hygiene 29328

							C	ertifica	ate of	Death			Reg. No.		
		_	1. Decedant's Name (First, Middle,	Last)								2. Dete of De		Vana	3. Time of Death
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н		1	Usual Residence of Decedent				_	1	1			TALL . J	0, 1931	ratt y	Idila
	ylen Wor		10e. Stete 10b. County			10c. C	ty, Town or	Location						1	Od. Insida City Limits
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	filed within 72 hours effer death with the Marylend Hygiene. ther than "natural", or itema 23a or 28a-f ahow ant, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Wa	s Decede	nt Ever in U	J.S. 13	B. Wes Dec			gin? (Sp	ecify Yas or No			an Indian,
	Her o	5	1 ☐ Nevar Married 2 🖾 Merrie	Am	Yas 2	s?		If Yes, sp	pecify Cubi	an, Mexicar	, Puarto	Rican, atc.)	Ble	ck, White,	etc.
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21215-0020	n 72 hours "natural",	8	15. Decedent's				16e Dec	edent's Us	suel Occur	etion			16b. Kind of B		
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an		ď	Cecil L.D. Edwa	rds						Pat	SV S	Simmons			
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<u>s</u>	d 2 sho d 2 sho th and 7 ia ma traum		Karen E. Edward												
o'	1 and Haaith em 27 ther tr	+	20e. Method of Disposition	s (spc	ouse)	20b.	Plece of Dis	position (A	leme of		Pal	Dete Dete	FL 342 20c. Location		own State
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#	tant tant	-	4 Donetion 5 Other (Spe			Da	rling					/9/98	Darling	ton,	Maryland
Baltimore,	permit. Pages 1 and 2 should Depentment of Haaith and Men Important: if Item 27 ia marke any injury or other traumatic ance.		21. Signature of Funeral Service Li	censee	1			22. Name	ing-C	ss of Fecilit	b Fune	ral Ho	me, P.A.		
ш	205 4 4		1 Committee	BI	500	1-0									
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2	/Medical		tmmediate Cause (Final disaese or condition		11	VER	FAIL	VRF							2 WEEKS
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	outed and ransi	Ē	Sequentially list conditions	b	111		or es e cons								7,00,000
ó	an ar rial-t	Ĭ	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury												
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89	iffical g ph	2	resulting in deeth) Lest					, , , , , , , , , , , , , , , , , , , ,	,						
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ص	that ded b											10	Yas 2 No	3 P10	bably 4 Unknown
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	hour hour mera ly fill		29a. Certifier 1 Certifying	Phyalcfan:	To the be	st of my kno	owledge, de	ath occurre	ed et the tir	ne, dete en	d place,	end due to the	ceuse(s) end m	enner es s	tated.
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral di	POICAL	(Check only 2 ☐ Medical E one)		the basis d menner		ation end/or	investigati	on, in my o	pinion, dea	ith occur	ed et the time,	dete and place,	and dua t	the ceuse(s)
	To the Company of the		29b. Signature and 1819 of certifier	100		1115		2	29c. Licans	a number			29d. Data signe	d (Month,	Dey, Year)
			> //h.h.	Show	this				AUY	17/4	SFG	127_	SEPTER	BED	6.1998
	0	-	30. Neme and eddress of person w	ho complete	d course	of death (Ita	m 23a) /Tree	a Print)	10//	10/1	4		اس سر		611118
	10		MICHAEL EL	20161	- Couse o	AAP	UMMS	7.7	2.	AFE	18 C	T 7.	TIMAL	111	6,1198
	Chat		31. Dete filed (Month, Dey, Year)	SOUTH	32 Bed	strada Sign	-	1	ne Va	T	2)	1 12/4	-///	1000	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physic /Medi		1. Decedent's Name (First, I	Aiddle, Las	1)	-174			Death	2. Date of Dea	th		3. Time of Death
				Ruth	Ann	ıa	ENGLANI		Septemb	per 9, 1	998	8:40 A.M
Exami	ner	4a. Factlity Neme (If not institute College)		4	ib. City, Town, or L Freder		4c. County	of Deeth	ick
Funeral Director		5. Social Security Number 213-74-0670		9X 7. A	ge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay Feb. 19	, 1897	9. Birthpl Count Mary	ace (State or Foreign land
ehow adat		10a. Stete 10b. Co			10c. City, To	own or Loc	cation				10	d. inside City Limits
28a-f ehor	ctor	Maryland F	reder	rick			Fı	cederick				1∭ Yes 2□ No
23a or	Funeral Director	10e. Street and Number 400 North	Aver	nue			10f. Zip Code 2170	01	1	0g. Citizen of W	hat Count	ry?
P F	by	11. Marital Status 1 ☐ Never Merrled 2 ☐ 3 ื Widowed 4 ☐ Divo		12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	?		Ves Decedent of H Yes, specify Cube ☐ Yes 2 (X)No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Biacl Specify:	- America k, White, e	tc.
ene. than *natural*, he Medical Ex.	Completed	15. Dec (Specify only h Elementary/Secondary (0- 7		ucation de completed) Coilege (1-4or	5+)		ent's Usual Occup kind of work done of NOT use retired Homemake	ation during most of work ()	ing	16b. Kind of Bu	siness/ind	,
and Mentel Hygiene. marked other than urnatic event, the M	Be Co	17. Father's Name (First, Mic	idle, Last)					18. Mother's Nam	e (First, Middle, i	Meiden Sumame	9)	
Mente Marked Matic e	To		Lee	MYERS				Ida			1MERM	
Ith and 17 is m		19a. Informant's Name/Rela Phyllis A. Kl]			end Number or Runge Road,				
ient of Health and Mentel Hygiene. nt: If Item 27 ie marked other than iry or other traumatic event, me M		20a. Method of Disposition 1 🖾 Burial 2 □ Creme 4 □ Donation 5 □ Othe	ion 3 🗆 1	Removal from State	20b. Place came	of Dispos	sition (Name of atory or other pled	е)	Date	20c. Location - (City or Tov	
Depertment of Important: If any injury or once.		21. Signeture of Funeral Ser	vice Licans	Ruby	MO07	703 K	Name and Address eeney & 1 06 East (ss of Facility Basford P Church St	A. Fundareet. Fi	eral Hon	ne c. MD	21701
physician end important the buriel-transit	edical Examiner	resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	{	o aci	Due to (or as	a consequence of the consequence	ence of):	cal fr	Joseph	u-		hous
physics the	0	resulting in death) Last			Due to (or as	a consequ	ence of):	Cordio	voscul	an I di	0 -	years
e ettending physled for use es the l		resulting in death) Last		d				en in Part I.	23b. Did to	obecco use con	tribute to	years the cause of death?
by the ettending leched for use ea	Physician/M	Part II. Other significant cor						en in Part I.				the cause of death?
s been signed by the ettending 2 should be deteched for use e	by Physician/M	resulting in death) Last						en in Part I.		n autopsy	3 Prob	
ete hes been signed by the ettending pege 2 should be deteched for use e	Completed by Physician/M	Part II. Other significant con	ditions co					en in Part I.	1 □ Y 24e. Wes a perfon	n autopsy	3 Proba	ably 4 Unknown The autopsy findings liable prior to a spletion of cause
cartificate has been signed by the ettending rector, page 2 should be deteched for use e	Be Completed by Physician/M	Part II. Other significant cor	ditions co	ntributing to death b	out not resulting	g in the und	derlying cause give	26. Place of Deat	1 U Y	n autopsymed?	3 Prob	ably 4 Unknown re autopsy findings lable prior to ripletion of cause eeth? Yes 2 No
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth September 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** Charles William Fuller.Jr. 16:38PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Anne Arundel Medical Center Anne Arundel 5. Social Security Number 577 - 34 - 5975 7. Age (In yrs. last birthday) 69 Yrs. 9. Birthplace (State or Foreign 1928 Wyoming 6. Sex M 2 □ F Director Usuel Residence of Decedent the Maryland permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mantal Hygiene.
Important: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show any Injury or other traumatic event, the Modical Examplest must be notified any once. 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Charles Director La Plata 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9628 Kline Drive 20646 Funeral USA 14. Reca - American Indien. 12. Was Decedent Ever in U,S.
Anned Forces?
1 Ê Yes 2 □ No
If Yes, Give
Year or Detes; Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Merried Specify: White 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sales Manager 12 3 Dairy 17. Fether's Neme (First, Middle, Last) Charles William Fuller Madge Louise Large Fuller 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drema Fuller/Wife 9628 Kline Drive La Plata, MD 20646 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cem. 9/18/98 Cheltenham, MD 22. Name and Address of Fecility AREHART-ECHOLS FUNERAL HOME P.A. 21. Signeture of Funeral Servica Licensee 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer feilure. List only one cause on eech line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Respiratory arrest Examiner cerebrovasculy acredon Examiner attending physician and for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Attiens cleves -Box 68760 Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? Records, P.O. signed by the in uffe very 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ^oL 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 28b. Time of 27. Menner of Deeth 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 5 Pending Investigation 1 Naturel death. 1 TYes 2 □No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 24 hours at Funeral D 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 20051437 MD 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) ANGE ARNDEL MEDICAL CENTLA. OXEOWD D. IBITOME 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature

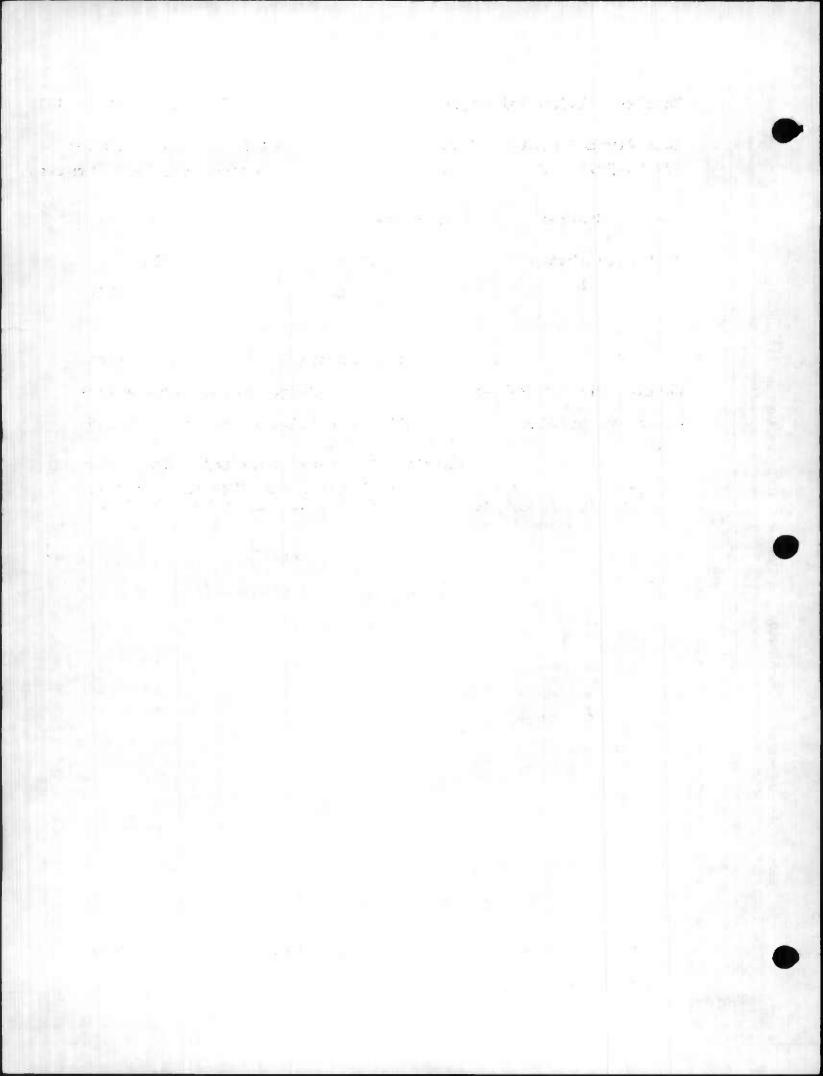
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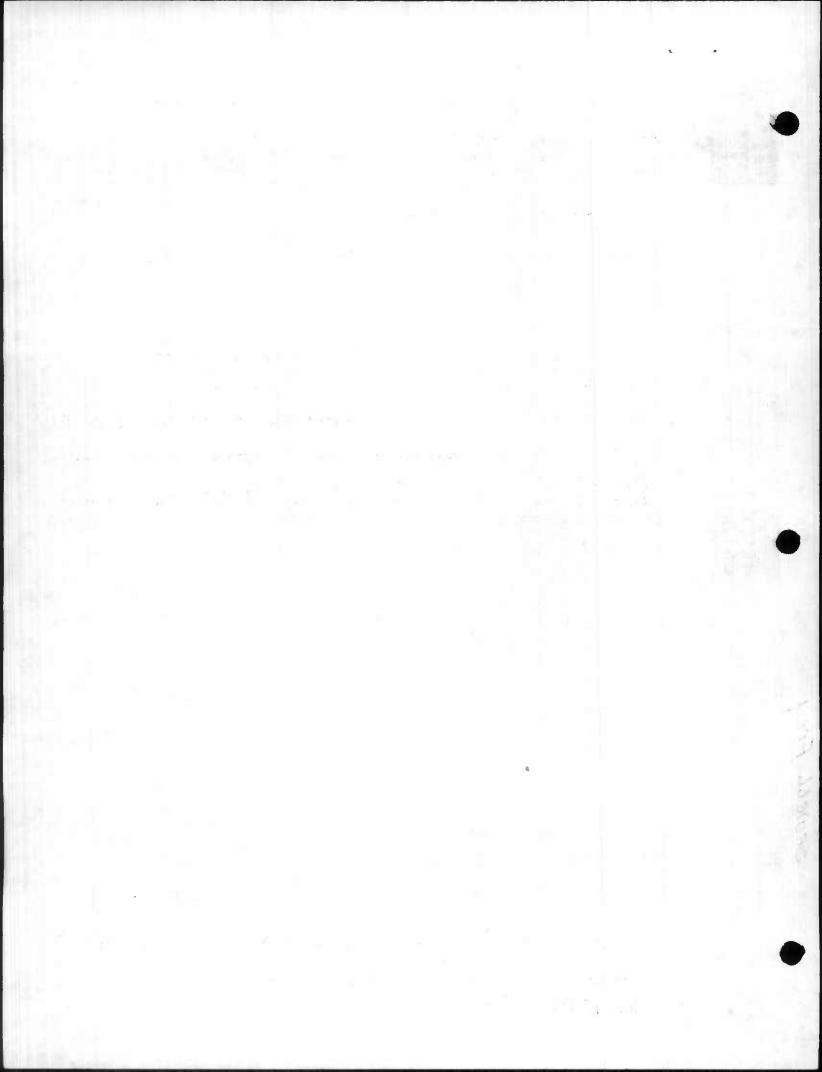


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death pey 13, 1998 9:25 AM **Physician** Sewell Adolph Frev September /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Dorchester Cambridge Dorchester General Hospital Hours Min. 8. Dete of Birth (Month Dey, Year)
April II, If Under 1 Yaar 5. Sociei Sacurity Number 6. Sex 1XXM 2□ F 9. Birthplece (Stete or Foreign Country) Mar yland 7. Aga (In yrs. last birthday) Funeral Days 84 Yrs. 1914 212-16-1206 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Dorchester Cambridge 1 Yas ANNO Director 10e. Street and Number 10f. Zlp Coda 10g. Citizen of Whet Country? 6 Nerns 23e 19 Algonquin Road 21613 permit. Peges 1 and 2 should be filed within 72 hours efter death. Department of Heelith and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event. Completed by Funeral US 12. Wes Decedant Evar in U,S. Armed Forces? MXYas 2 □ No If Yes, Give Yaer or Datas: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 1 Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify: ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Cemetery Superintendant State Cemetery System Baltimore, Maryland 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Joseph Frey Norma Moore 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20,000 Boxwood Circle Hagerstown, Maryland 21742 J. Scott Frey 20b. Piece of Disposition (Name of cematery, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXCremetion 3 ☐ Removal from State 9/17/98 Salisbury, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crematory unerei Sarya Licansee 22. Name end Address of Fecility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 23e. Per Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, show or heart feilure. List only one cause on each line. Approximate Intervel Between **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Emphysema **Examiner** Examiner The law requires that the death certificate be executed signed by the attending physician end d be deteched for use as the buriel-tran Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 → Yes 2 No 3 □ Probably 4 □ Unknown þ 24b. Were eutopsy findings evalleble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed After this certificate 1 Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA within 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funeral of 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 DNature 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 Suicida 6 Could not be determined 28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifler (Check only one) 29b. Signeture and title of cartifier 29c. Licensa number 29d. Dete signed (Month, Day, Year) 14/98 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) James Zimmerly, M.D. 300 Byrn St Cambridge MD 21613 32 Registrer's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene

							Certifica	te of	Death		F	leg. No.			
	Dhusia		1. Decedant's Neme (First, Midd				11 11				2. Data of Dee	th	Voor	3. Time of	Death
	Physic /Medi		Aaron		Fow1e	r					Septemb	er 7, 1	1998	12:25	A.M.
}	Exami		4a. Facility Name (If not institution 505 Armiger		umber)				-	own, or L ting	ocation of Deeth	4c. County	of Death Lvert		
	Funeral Director		5. Sociel Sacurity Number 185–16–3054	6. Sex 1 ☑ M 2 ☐ F	7. Aga (in	yrs. lest birth	Months rs.	Dayı		24 Hrs. Min.	8. Data of Birth July 10	Year 1919	9. Birthp	elece (Steta c etry) rginia	r Foreign
	pu .		Usuel Residence of Dacedant 10e. Stete 10b. Count		10	o City Town	an Landian	-							
	se-f sho	ector	Maryland Cal	vert		c. City, Town Hun	tingto	wn	_					0d. inside Cl	-
	th with the 23a or 2	Funeral Director	10e. Street and Number 505 Armiger	Road			10f. Z	p Code 2	0639		1	0g. Citizen of V USA		ntry?	
21215-0020	pormit. Peges 1 and 2 should be filed within 72 hours after deeth with the Manyland Depertment of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show shy lajury or other traumatic event, the Medical Examiner must be notified at ance.	by	11. Marital Status 1 □ Never Merried 2 ☑ Ma 3 □ Widowed 4 □ Divorce		orcas? 2 □ No 1	941- 945	13. Was Dace If Yes, spo 1 ☐ Yes				acify Yas or No- Rican, atc.)		ck, White, Che	an Indien, etc. rokee ian	
5-0	72 h	etec	15. Deceder (Specify only higher	nt's Education est grada complated)	1	Decedent's Usi 'Giva kind of w	ork done	durina mos	t of work	ina	16b. Kind of B		-	
121	within	Completed	Elementery/Secondary (0-12)		(1-4or 5+)		ivy Equ	use retin	ed)			Power	r Pla	nt	
64	Hygie ther ther		17. Fether's Neme (First, Middle	Last)	-	nea	ivy Equ	Thile	1		a (First, Middle, i			II C	
Maryland	d 2 should be filed within th and Mentel Hygiene. 7 Is marked other than 'treumatic event, the Me	To Be	Walter		F	owler			Estl				Brow	n	
-	Tand 2 sh Health end em 27 is m other treum		19e. Informent's Neme/Reletion Edna Fowler/Wi			50	5 Armi	ger	Road		ntingtov				
Baltimore,	Peges 1 nent of He int: If item		20e. Method of Disposition 1 XBurial 2 Cremation 4 Donetion 5 Other (5		State S	Ob. Plece of I cematary outher	Disposition (Ne cremetory or n Memo	me of other pl rial	Garde	ens	Dete 9/11/98	20c. Location - Dunki			
Balt	permit. Peges Depertment of I Important: If ite any Injury or of		21. Signeture of Funarel Service	Licensee	00				ess of Fecili	De	well Fur			MD 20)678
	Physician		23a. Pert1. Entar the disaese, o shock, or heart feilure. Lis				ot entar tha mo	da of dy	ing, such as	cardiac	or raspiratory arr	ast,		Approximate Intervel Bett Onset and I	e ween
	/Medical Examiner	e.	Immediate Cause (Final disassa or condition resulting in deeth)	e. TE			onsequence of		A.	L	JHU	7			
ć	exacuted n and iei-transit	Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury	b. —	Due	to (or es e co	ensequence of)	•							
x 68760,	death certificate be executed e attending physician and ad for use as the bunel-transit	/Medical	Cause (Disease or Injury that initiated events resulting in daeth) Last	c	Dua	to (or es e co	nsequence of)								
Вох	attend for us	clan										/			
P .	thet the d	Physician	Pert II. Other algnificant conditi	ons contributing to c	deeth but no	t resulting in t	the underlying	cause g	iven in Pert i	l.	23b. Dld 16	es 2 No		the cause of the c	
Vital Records,	sw requires s been sign 2 should be	Completed by		11-1				5.			24e. Wes a perfor		8V	ere autopsy f aliable prior t mpletion of c death?	0
T I	The page	Com									1 □ Y	as 2 No	1 E	JYes 2□	No
II a	ician: The certificate rector, pag	Be	25. Wes case referred to predice examinar?						26. Place	of Deet	h (Check only	(a)			
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מכ	leath. lor: After the funer	lon	27. Menner of Death 1 Neturel 5 Pendi		of Injury oth, Day Yea	28b. Tir Inj		28c. Inju			28d. Dascribe ho	ow Injury occur	red		
Division	or Attending efter death. Director: After i in by the fune	Certification:	2 Accident investi 3 Sulcide 6 Could 4 Homicide determ	not be	e of Injury - ling, etc. (S)	At home, fam	M n, street, fector		Yes 2	-	28f. Location (S) City or Town	reet end Numb n, Stete)	er or Rura	l Route Num	ber,
	To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by th	edical Ce	(Check only 2 Medical	ng Physician: To the Examiner: On the b	pasis of exam	knowledge, ominetion end/	deeth occurred	at the t	lme, dete en opinion, dee	d plece,	end due to the or	euse(s) and ma	enner as si	ated.)
	To the within 2 To the comple	Med	29b. Signature and titla of certifie	end mar	nner steted.				se number	0		9d. Dete signe			
			30. Neme end eddress of person	0,0	se of death	(Item 23a) (T	vpe, Print)	D	1111	8 0	610	11919	NIA	,	
			The Section of person	completed each	or weall	(200) (1	, po, . mil)	1	OUT	110	tce	70120	CUM	1	
	Sta Registr		31. Date filed (Month, Dey, Year)		Ragistrar's S		6. 1	300	1						

Langer.

Months

10f. Zip Code

21754

1 ☐ Yes 2 XNo Specify:

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility Stauffer Funeral Home

, Jr.

Yrs.

Plasterer

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ebeneezer U.M. Cemetery

10c. City. Town or Location

Ijamsville

7. Age (In yrs. last birthday)

79

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes . 2 10 No If Yes, Give Yeer or Dates:

College (1-4or 5+)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City. Town, or Location of Death

Frederick

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

18. Mother's Name (First, Middle, Maiden Sumeme)

Date

Nellie Bowie

9229 Fingerboard Road, Ijamsville, MD

ter the mode of dying, such as cerdiec or respiretory arrest,

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1621 Opossumtown Pike, Frederick, MD

Coples A		Die.	
ental Hygie	ene y	8	29333
Reg	. No.		
2. Date of Death Month	Day	Year	3. Tima of Death
Septembe:	r 10,1	998	6:25 AM
cation of Death	4c. County	of Deeth	
c	Fre	deri	ck
8. Date of Birth (Month, Day, Y	ear)	9. Birth	place (State or Foreign
April 27			ryland
		-1	10d. Inside City Limits
			1 ☐ Yes 2 📉 No
10g	. Citizen of \	What Cou	intry?
υ	nited	Stat	tes
cify Yes or No- Rican, etc.)	14. Rec		ican Indian,
noari, oto.)	1.45		
	Specify	/: B1	.ack
ng 16	b. Kind of B	usiness/ir	ndustry
	self		

21754

21702

Approximate Intervel Between Onset end Death

Kay

24b. Were autopsy findings aveilable prior to completion of cause of deeth?

1 TYes 2 No.

21702

REDERICK

20c. Location - City or Town, State

9/14/98 Ijamsville, Maryland

with the Maryland permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modical Example of the profiled and once. Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

214-14-6383

10e. Street and Number

10a State

Directo

Funeral

by

Completed

Be

Usual Residence of Decedent

4a Facility Name (If not institution, give street end number)

10b. County

9229 Fingerboard Road

John R. Foreman, Sr.

Mildred Pryor Foreman/ wife

1 X Buriat 2 Cremation 3 Removal from State

23a. Part1 Enter the disease, or complications that ceused the deam shock, or heart failure. List only one cause on each line.

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

15. Decedent's Education (Specify only highest grade completed)

Maryland Frederick

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Elementery/Secondery (0-12)

17. Father's Name (First, Middle, Last)

10

20a. Method of Disposition

College View Nursing Home

6. Sex

1 XM 2 □ F

Physician /Medical Examiner

Examiner physician end the burial-transit Physician/Medicai as esn signed by the a þ Completed is certificate hes director, paga 2 Be 2 Certification:

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i

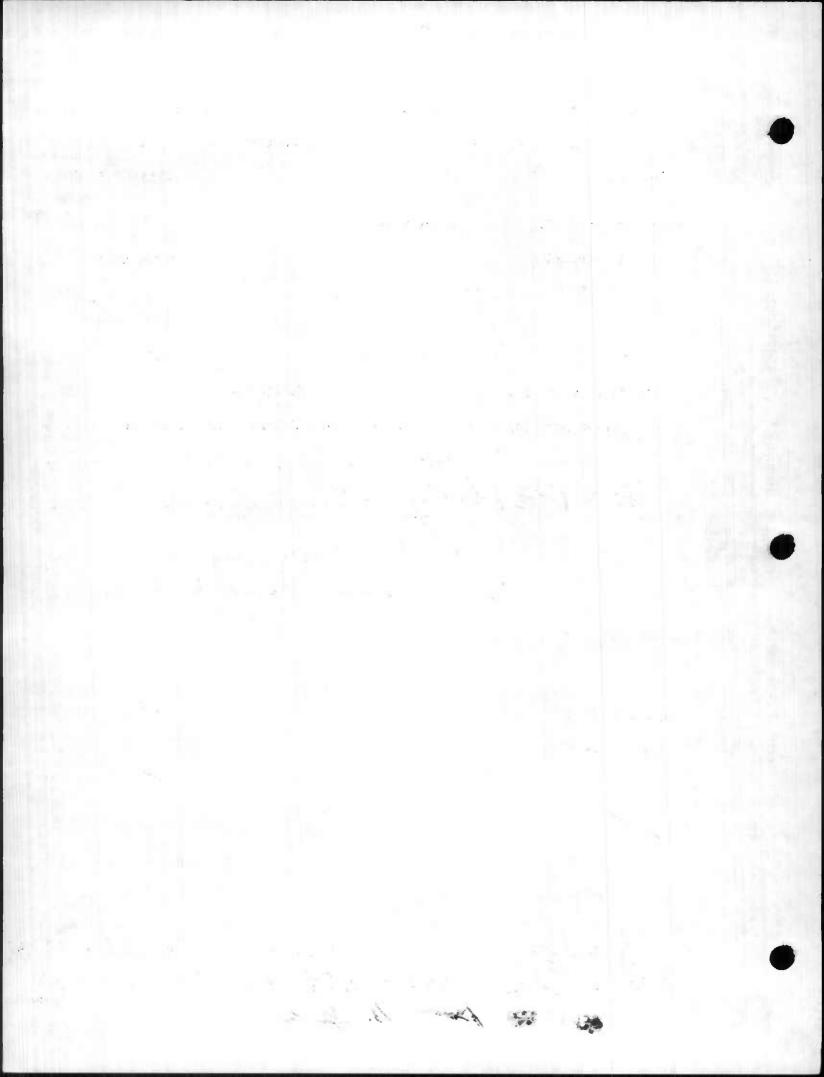
Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es e consequence of): Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Part II 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1□ Yes 2□No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) and menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

State Registrar

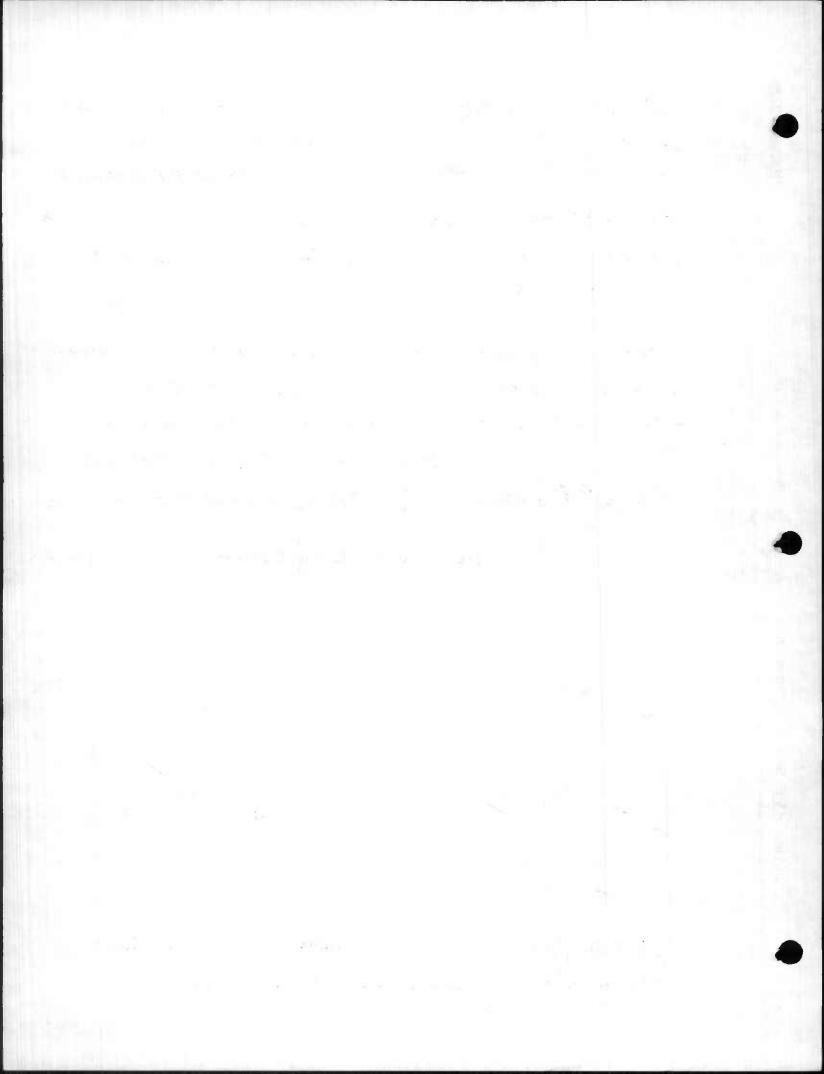
Medical



State of Maryland / Department of Health and Mental Hygiene

98 2933

Physicia	_											
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/Medica		4a. Facility Name (If not institution, g	rive street and number	77/			th City Tow	n or 1 oos	ition of Death	196 71	1998	0,000
Examine	er	the state of the s		")			-		/ Death			/
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Funeral		Social Security Number 6.	Sex 7. A	age (In yrs. les	Mon	nder 1 Year ths Days	If Under 2	4 Hrs. 8	Dele of Birth (Month, Day	Yeer)	9. Birthp	place (State or Fore
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items free rra	Funeral Director	11. Marilal Stalus	12. Was Deceden Armed Forces	t Ever in U,S.	13. Was D	ecedent of H specify Cuba	ispanic Origi	in? (Speci	ty Yes or No-		ce - Americ	
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- 2	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dales	:	10 46	5 2 2000	Specify:			Specif	y: Wh	MITE
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other vent,	ŏ	17. Father's Name (First, Middle, Las			1100	171070	,				-	9771100
d of	Be						16. MOTHER	s Name (/	rirst, Middle, i	Maiden Suman	ne)	
marked o	2	HARRY E.	GRAY				mai	26-A1	RET	5 Cho	144	
ie me		19a. Informant's Name/Relationship	(Type, Print)		19b. Malting Add	lress (Street						
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Heelth Jern 27 Sther tr		20a. Method of Disposition		20b. Plac	e of Disposition	(Name of				20c. Location	City or To	own. Slate
		Burial 2 ☐ Cremelion 3		e cem	etery, crematory				17.			
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Department of Her Important: If Item any Injury or othe once.		21. Signature of Funeral Service Lice	intega		22. Nam	e and Addres	ss of Facility				7	
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	-	23a Part1 Enlor the disease or an	molications that save	ad the death. I	Dee					9 E.M.	114/1	1.00
3	- 1	23a. Part1. Enler the disease, or con shock, or heart failure. List onl	y one cause on each	line.	Do not enter the	mode of dyin	g, such as ca	ardiac or r	espiratory arr	est,		Approximete Interval Between
ysician												Onset and Death
Medical		Immediate Cause (Final disease or condition	V	10								
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death September 5, 1998 Harry Herbert Giles, Sr. 2135 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Havre ue ... | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Mar. 6, 1912 Harford Memorial Hospital Harford 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 217-12-7959 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 11 Yas 2 □ No Maryland Harford Aberdeen 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 766 Everist Drive 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 ₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Care Taker 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Isaac Franklin Giles Annie Elizabeth Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne A. Giles (Daughter) 766 Everist Drive, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 9/10/98 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Mt. Calvary Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused an equitf. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each june. Approximate Interval Batween Onset and Death Immediate Cause (Final disease or condition resulting in death) / Respiratory insufficiency Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yea 2 No 3 Probably 4 Unknown Chronic Obstructure Pulmonay Congestive hear failure 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Paralytic Gleus / Bysphages 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

D43115

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

9-6-98

Physician /Medical Examine

Baltimore, Maryland

1 and 2 should be Health and Mental

rtant: If Item 27 I

extenden 5, 1998

Harry

Physician

/Medical

Examiner

Directo

Funeral

Director

Physician/Medical Š Completed Be 10 hours after death.

Records,

Sais Division of Vital

0

24 hours

31. Data filed (Month, Day, Year) State SEP Registrar

27. Manner of Death

Natural

2 ☐ Accident

4 Homicide

29b. Signature and title of certified

3 ☐ Suicide

29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRZA ASBAG

5 Pending investigation

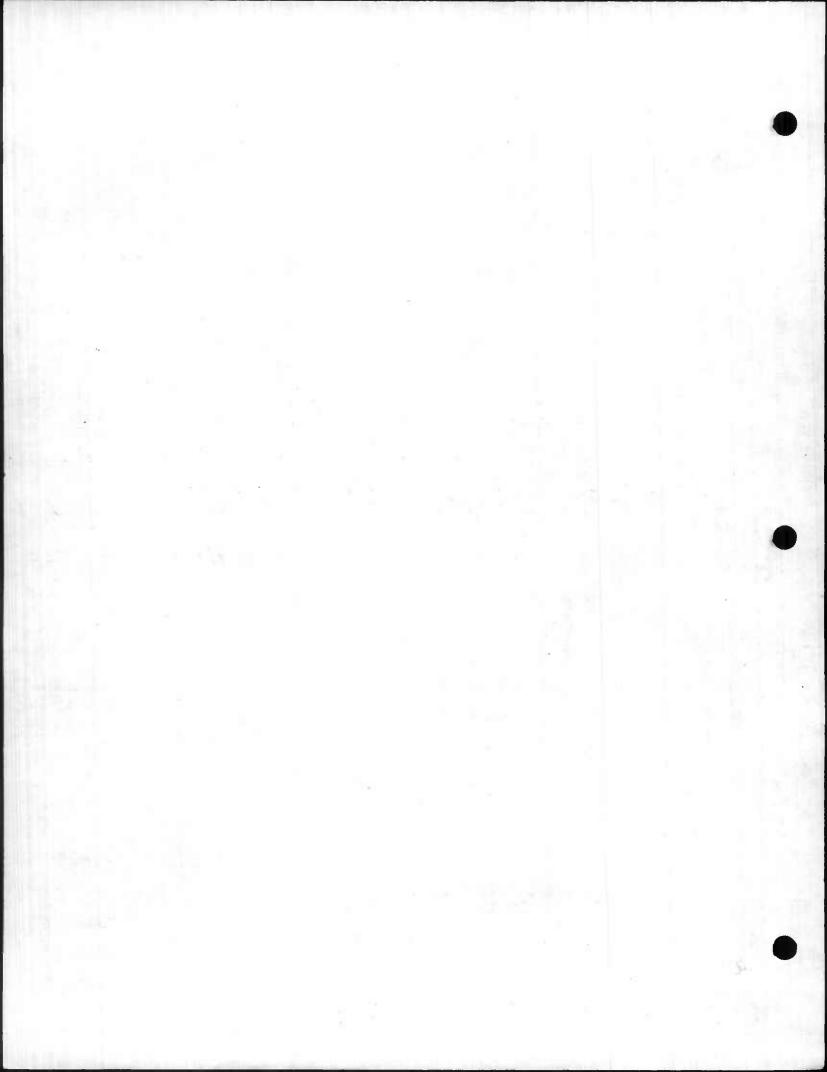
6 Could not be

615, Sumon Are, Have De Grace MD 21078

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



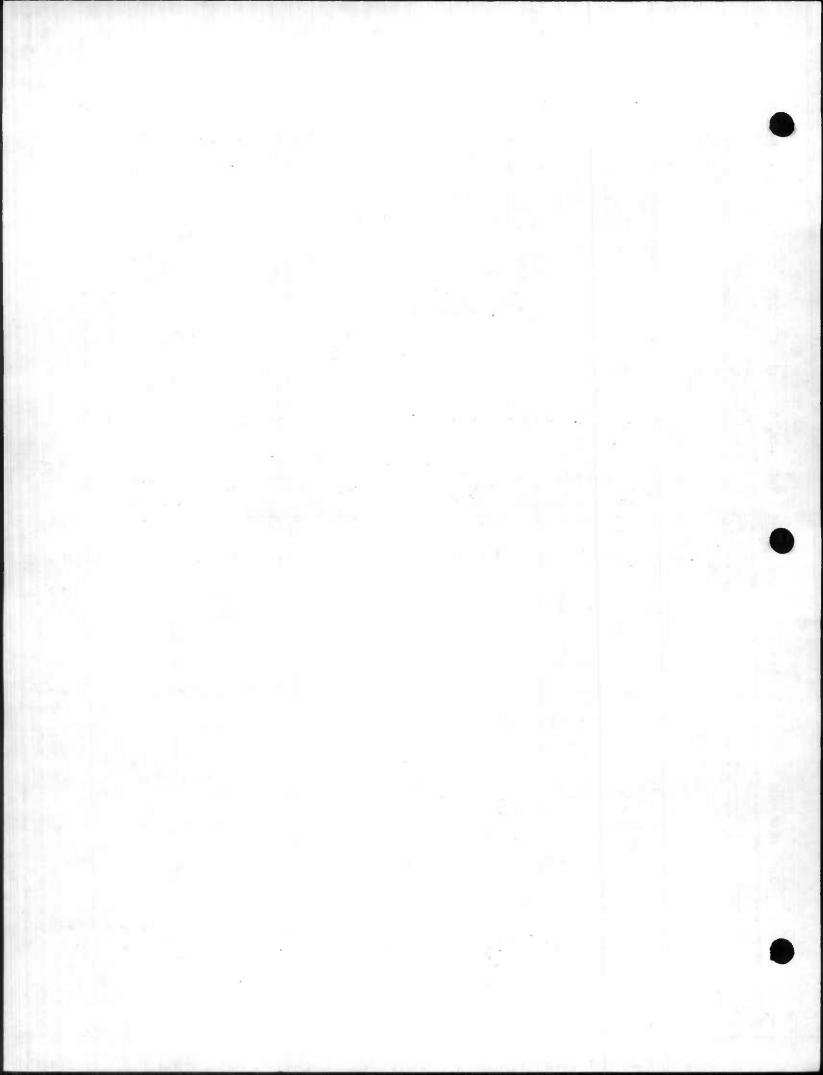
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician JOSEPH** WALLACE GARNER SEPTEMBER 10, 1998 05:30 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK CALVERT Hours Min. OCTOBER 27, If Under 1 Year 9. Birthplaca (State or Foreign 1922 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Yrs. 75 577-20-6884 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exercises must be notified at 1 Yes 2 No Director MARYLAND PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9208 DANDELION LANE U.S.A. 20772 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 \(\text{Yes} \) 2 \(\text{No U \cdot S \cdot ARMY} \)

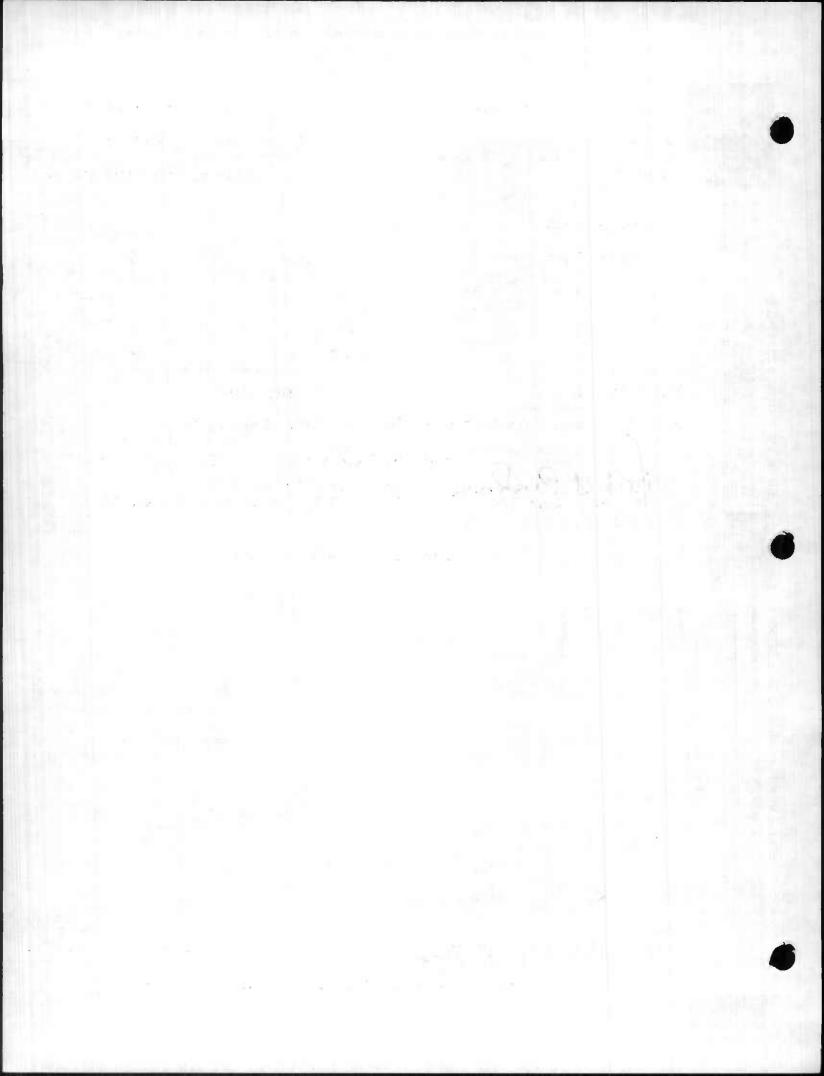
If Yes, Give

1 \(\text{Yes, Give} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: WHITE à 3 ☑ Widowed 4 ☐ Divorced 22MAR43 -180CT45 Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ENTWISTLE BLOCK Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled wit Department of Health and Mental Hygiera Important: If tam 27 is marked other tha any hijury or other traumatic avent, train ponca. EQUIPMENT OPERATOR COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERMAN PRESTON GARNER DAISY VERONICA PARKER 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORRAINE A. BAUCKMAN / DAUGHTER 12835 WALDORF FOREST ROAD, WALDORF, MD 20601 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1X Burial 2 Cremation 3 Removal from State MARYLAND VETERAN'S CEMETERY 9-15-1998 CHELTENHAM, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Seofca Licensee THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 1PK MARK G. BROHAWN M00053 156, WALDORF, MARYLAND 20604-0156 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final INTRA CEREBRAL HAEMORRHAGE disease or condition resulting in death) Examiner Due to (or as a consequence of) > 2 YRS EREBRAL ATHEROSCLEROSIS burial-transit and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown PERIPHERAL VASCULAR DISEASE Records, by 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? ARTERY DISEASE completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital 25. Was case referred to medical Be 26. Place of Deeth (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Neturel he Hospital or Attanding in 24 hours after deeth. he Funeral Director: Afte pletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) au chad aus D 50653 9-10-1998 m.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7501 . SURRATTS ROAD. CLINTON . M.D. GYAN CHAND SURANA. 32. Registrer's Signature State Jenera Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 13 1998 2:49PM **Physician** Grace Edwards Goodman /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles 105 Gentry Court Bryans Road 5. Social Security Number If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X Months Days Hours Min Yrs. 579-16-2086 93 July 2, 1905 Raleigh, Director Usual Residence of Decedent the Marylend 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Directo Maryland Charles Bryans Road 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code with 1 105 Gentry Court 20616 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Pages 1 end 2 should be filed within 72 hours efter nent of Health and Mental Hygiene.
int: If Item 27 Ia merked other then "natural", or ite Iry or other traumatic event, the Medical Examina 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 White 1 Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Thomas Edwards Mary Edwards 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty A. Goodman - Daughter-in-law 504 Oak Drive, Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 DBurgal 2 DCremation 3 DRemoval from State permit. Page Department of Important: If any injury or Cedar Hill Cemetery 9-17-98 4 Donation 5 Other (Specity Suitland, MD underal Service Libera 21. Signu Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156 Mark G. Brohawn M0053 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Colorectal Cancer with Metatasis Examiner Due to (or as a consequence of) Examiner buriel-transi Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): pue certificate be exec Box 68760 physician Physician/Medical the Due to (or es e consequence of): as for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed peen completion of cause of death? certificate has 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physicien: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 14,1998 D28352 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Krishan Mathur, MD., P.O. Box 2729, La Plata, MD 20646 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 16 1998 Registra



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Marylai		tificate of		viernai my	Reg. No. 98	2.9338
	Physician	Decedent's Name (First, Middle, Last,					2. Date of De Month	Dey	3. Time of Death
2.	/Medical	JUANITA E. GREE	N				Sept.	1	12:14 P.M.
	Examiner	4a Facility Name (If not institution, give				4b. City, Town, or l			
PAIL.		SOUTHERN MARYLA			W.1. 1 111	Clinton			e George's
	uneral irector	5/9-32-48/8	7. Age (In yrs	. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De June 1		9. Birthplace (State or Foreign Country) Washington, D.C.
yland	B #	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside City Limits
Ma	otor oto	Maryland Prince Ge	orge's	4701 Hor	mer Aven	ue #D, Su	itland		1 Yes 2 No
h with th	23a or 28a-1a at be notified al Director	10e. Street and Number 4701 Homer Avenu	e #D		10f. Zip Code 2074	6		10g. Citizen of W United	hat Country? States
5-0020 72 hours after death with the Maryland	"natural", or frame 23a or 28a-f ahow added Examiner must be notified at letted by Funeral Director	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		Ves Decedent of H Yes, specify Cub ☐ Yes 20 No	lispanic Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or No Rican, etc.)	14. Race Bleck Specify:	- American Indian, K, White, etc.
within		15. Decedent's Edu (Specify only highest gred Elementery/Secondery (0-12)	cation e completed) College (1-4or 5+)	16a. Decede (Give k life, D	ent's Usual Occup ind of work done O NOT use retire Housewi	during most of world)	king	16b. Kind of Bus	
D # 1		17. Father's Name (First, Middle, Last)			Housewi		ne (First, Middle	, Maiden Sumame	
yian Mental		Arthur Green					Harley		
Tarylan 2 should be	marke matic	19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Meiling	Address (Street	and Number or Ru			State, Zio Code)
	2 2	LaVerne Barnum -				Way South			0774
re, N s 1 and 3		20e. Method of Disposition			ition (Name of atory or other pla		Date		City or Town, State
Pages	-	1 □XBuriel 2 □ Cremetion 3 □ F 4 □ Donetion 5 □ Other (Specify)	remover from State		morial Par		0/12/08	Tandovos	r, Maryland
Baltimore, permit. Pages 1 ar	Important: any injury 8868.	21. Signature of Fugeral Service Licens		22.	Name end Addre	ss of Facility		Landove	r, maryland
D	A P	Ilal TX	trunk TII	STE	EWART FU	NERAL HOM	E, Inc.		
	sician	23a Furt1. Enter the diseese, or completed, or heart failure. List only or	icetions thet caused the dea	th. Do not ente	r the mode of dyi	ng Road, ng, such es cardiac	or respiretory a	ashingto rrest,	n, D.C. 20019 Approximete Intervel Between Onset and Death
The state of the s	edical aminer	Immediate Cause (Final disease or condition resulting in deeth)	Due to (or as a consequ	Ω	· · · · · · · · · · · · · · · · · · ·			1
58750, Icata be executed	physician and s the buriel-transit	Sequentielly list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury	Dea po	or es e consequ	pence of):	tus.			
Goath certificate be ex		thet initiated events resulting in death) Last	Due to (d	or es e consequ	ence of):				1
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J. st.	s signed by the attending lid be detached for use a d by Physician/M	Congan	ive Hear	t Fa	lure			•	3 Probably 4 Unknown
HECORDS, P.O.	shou							an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
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2 2	rector, pag	25. Wes case referred to medical				26. Placa of Dea	ith (Check only	one)	
Of VICE	9 5	exeminer?	lospitel: 1 🗵 Inpatient 2 🗆	ER/Outpatient	3□ DOA Of	ner: 4 Nursing H	ome 5 Res	idence 6 Othe	er (Specify)
E 8	After th funeral	27. Menner of Deeth	28a. Dete of tnjury (Month, Day Year)	28b. Time of tnjury	28c. tnju Wo M 1 □	ry et rk? Yes 2 □ No	28d. Describe	how injury occurre	bed
DIVISION To the Hospital or Attend within 24 hours after death	al Director: After the od in by the funeral Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At I building, etc. (Speci	nome, ferm, stre	et, factory, office		28f. Location (City or To	(Street end Numbe wn, State)	er or Rural Route Number,
e Hospit	To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	tician: To the best of my known or: On the basis of examination end menner steted.	owledge, death ation and/or inve	occurred at the tile estigation, in my o	me, date and place opinion, death occu	, and due to the rred et the time,	cause(s) and mar date end place, a	nner as stated. and due to the cause(s)
To th	To the	29b. Signeture end title of certifier			29c. Licens	se number			(Month, Day, Year)
	7	> allIau	W		DI	5705		9-9	-98.
(3)	30. Name and address of person who co	empleted cause of death (Ite	41)		Hill Ro	ad Over	n Hill N	4D 20745
	State	31. Dete filed (Month, Day, Year)	32 Registrar's Sign		P OXOI	m IIIII RO	ad, UXO	1 LLLL 1	20143
	Registrar	SEP 1 1 1998	Comment of the same	A.	for d				

SEP 2 2 1996 James 4 June

State of Maryland / Department of Health and Mental Hygiene

Physici		 Decedent's Neme (First, Middle. 	Last)					2. Date of De			3. Time of Deeth
		William C. G	riffin,	Jr.				Sept.	4,199	Yeer 5	5:03 P.M
Medio/ Examin		4e. Fecility Neme (If not institution,	give street end num	iber)			4b. City, Town, o	r Location of Deeti			
	•	Prince George	's Hospi	ital	Center		Cheve	rlv	Princ	e Geo	orge's
uneral rector		5. Social Security Number 249-24-7426			s. lest birthdey) Yrs.	If Under 1 Ye Months De	ear If Under 24 Hi	s. 8. Date of Bir	th ly Yeer)	9. Birthplee	ce (State or Foreign
*		Usuel Residence of Decedent 10a. Stete 10b. County		10c. C	City, Town or Loc	cation				100	d. Inside City Limits
or 28a-f show	tor	Md. P.	G.		Palmer					100	1 √Yes 2 No
or 28	Direc	10e. Street end Number				10f. Zip Cod	le		10g. Citizen of	Whet Country	y?
23a	a	2307 Penbr	ook Circ	cle		207	785		U.S.	Α.	
"natural", or items 23a or 28a-f sho soical Examiner naust be notified at	by Funeral Director	11. Meritel Stetus 1 □ Never Merried 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decer Armed Ford 1 Tyes If Yes, Give Yeer or De	ces? 2 ፟፟፟፟ No		Ves Decedent Yes, specify C	of Hispanic Origin? (Cuben, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)	Specify	ce - American ck, White, etc y: Bla	c.
Jical I	sted	15. Decedent's (Specify only highest	Education		16e. Deced	ent's Usuel Oc	cupetion	orkina	16b. Kind of B	usiness/Indu	stry
	Completed	Elementary/Secondery (0-12)	College (1-	4or 5+)			ne during most of w tired)				
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tem 27 is marked of other traumatic eve	F	19e. Informent's Name/Reletionshi		TILLOI		a Address (Str	eet end Number or I	sie Fra		State Zin C	inde)
		Barbara Mack/I					10 abov		.,, ,	0.0.0, 2.7	-
item 27 i other tra		20e. Method of Disposition		20b.	Place of Dispos cemetery, crem	sition (Neme of		Dete	20c. Location	- City or Town	n, Stete
4: 4		1 Buriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		late			9/	11/98	Laurel	. Md	
Important: any injury ance.				ма	ryland	Nat Name end Ad	L. Mem. P	k.			
Important: If ite any injury or ot once.		21. Signature of Funerel Service Li 23e. Pert1. Enter the disease, or c shock, or heart failure. List o	NC	1 2	× 1	H.S.Wa	shington	a & Son	s Co.	, Inc.	
		23e. Pert1. Enter the disease, or o	omplications that ca	used the dea	th. Do not ente	the mode of	dving such as cardle	S AVE.	N.E., W.	ash.,	D.C.
	di.				or as e consequ		Cardio	Aswar	DITORE	2	1ears
buriel-transit	cal Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events	b	Due to (or as e consequ or es e consequ	uence of): uenca of):	Cardio	Aswar	017008	2	read
	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest	c	Due to (or as e consequ	uence of): uenca of):	Cardio	/ASWAY	017478		Jeans .
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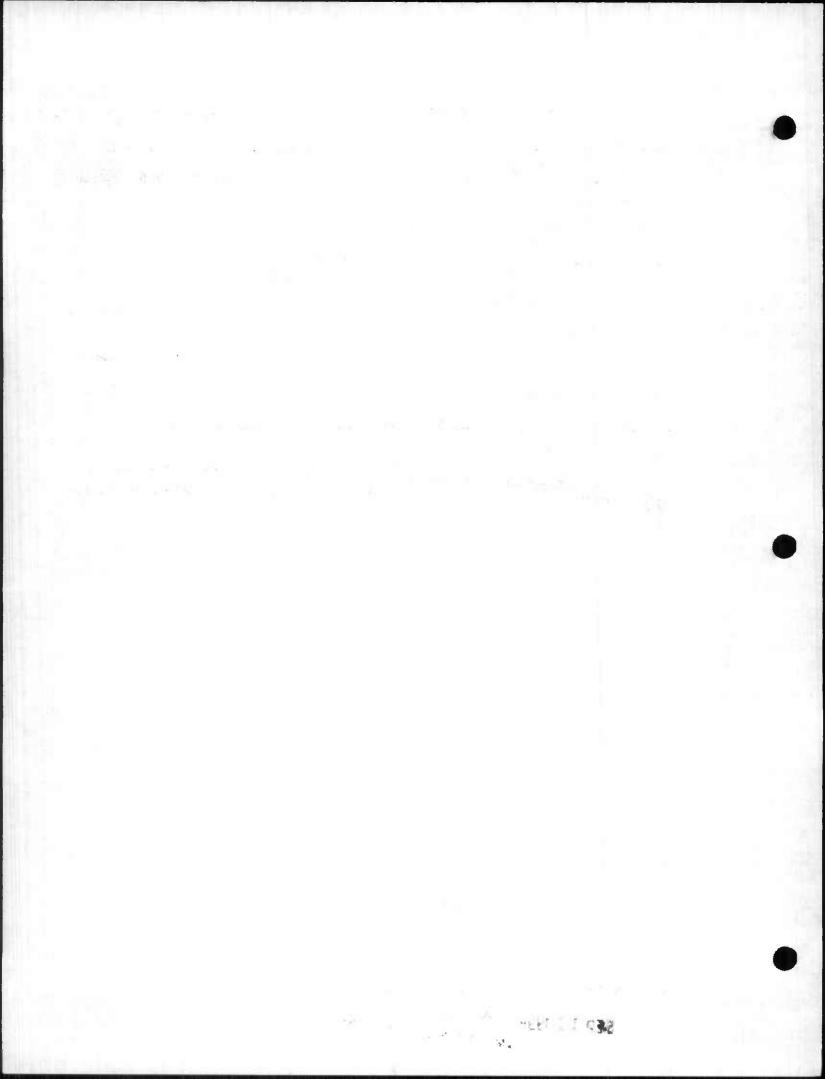
State of Maryland / Department of Health and Mental Hygiene

hysician /Medical	_	. Decedent's Name (First, Middle, I	.ast)	65	46.00			2. Dete of Dee	Reg. No.	Yeer	Time of Deeth
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xaminer	1	e. Fecility Neme (If not institution, g 7743 MUNCY ROAD	ive street and numb	er)			LANDOVE	or Location of Deeth			retic
neral ector			Sex 7. 1 □ M 2 🕅 F	Age (In yrs	. last birthday) Yrs.	If Under 1 Ye Months De	er If Under 24 H	rs. 8. Date of Birt	n v, Year)	9. Birthplece Country) GEORG	(State or Foreign
notified at		0e. State 10b. County		10c. C	ity, Town or Loc	ation				10d. Ir	nside City Limits
tor led	1	MARYLAND PRINCE	GEORGE'S	L	ANDOVER					1	☐ Yes 2 No
	1	0e. Street end Number 7743 MUNCY ROAD				10f. Zip Cod	le 20785		10g. Citizen of UNITED		
by Funeral		1. Maritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? X No	lf.	as Decedent Yes, specify C	of Hispenic Origin? Cuban, Mexican, Puo No Specify:		14. Red	ce - American Inck, White, etc.	
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BeC	1	7. Fether's Name (First, Middle, Las	it)		HOLLE	писыс	18. Mother's N	eme (First, Middle,			
ToB	-	JOHNNIE BEASLEY 9e. Informent's Neme/Reletionship	(Time Print)		10h Mailing	Address /Str	DOROTH:	IE WHITE	City on Town	Chata Zin Ond	
other traumatic event,		JANICE B. YOUNG					NT PLACE,				•
5	2	0e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3	Removel from Ste	te	Plece of Disposi cametery, creme	ition (Neme of etory or other	plece)	Dete	20c. Location	City or Town, S	itete
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any injury or once.	-	• Signature of Parish Service La	John	uses	FOI	RT LINC	dress of Fecility COLN FUNE DENSBURG		TWOOD.	MARYT.AN	D 20722
sa as the bunel-transit /Medical Examiner	Sif oCt	seculting in deeth) sequentially list conditions, eny, leeding to immediate ause. Enter Underlying euse (Disease or Injury net initiated events esulting in deeth) Lest	b. RESPI	Due to (c	or es a conseque Y DISTRI or es e conseque or es e conseque	ESS ence of):					
cian/N	-	and II. Ohborn alma Married and distance									
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miner	_	a Facility Name (Laurel R								Laure		cation of Deat	- 27	ty of Death	orge's
2001		Sociei Security N		6. Sex	-	7. Age (In yrs	. last birthday	y) If Und	er 1 Year	If Under		8. Date of Bir			place (State or Fore
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by Funeral Director		1 ☐ Never Marr 3 🖾 Widowed		rried	Armed Fo	rces? 2 No 19.	41-	if Yes, sp 1□ Yes			, Puerto	ecify Yes or No Rican, etc.)		ack, White, ity: Wh:	etc.
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		9a. informant's N											er, City or Tow		
	-	Daniel Moe. Method of Dis		son -	- 50n	20b.					Sev	Date P	ark, Ma 20c. Location		
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Examin Funeral Director	er	216-14-6557			If Under 1 Yeer Months Deys	THURMONT II Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, De	FREI	9. Birthpie	K ce (State or Foreig y) (LAND
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28a-f shon notfried at	ctor	MARYLAND FREDERI	CK THUR	MONT						1 N Yes 2 N
or 26	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of W	het Count	γì
or items 23s	y Funeral Director	20 EAST MOSER B 11. Maritel Status 1 Never Merried 2 Married	D . 12. Wes Decedent Ever In U,S Armed Forces? 1 ☐ Yes ② No If Yes, Give	lf Y	es Decedent of H Yes, specify Cubs	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- America k, White, e	
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Department of Haalth and Important: If item 27 is many injury or other traum 900.8.		21. Signeture of Funerel Service Lie	DIIO	22.1	E CEMETI Name end Addre BERT E.		/11/98 SON FU	THURMON NERAL HO		
=0.		23e. ਜੰਗੀ. Enter the disease, or con ahock, or heart failure. List onl				MAIN ST.,				Approximate
oearn cernincata be executed e attanding physician and of for usa as the burial-transit	/Medical Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last	b. Due to (or a	es e conseque	ence of):					
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page	Con						101	es 25No	1 🗆	Yes 2□ No
is cartificata has director, page 2	Be	25. Wes case referred to medical examiner?	Hospitel:		Oth	28. Place of Deeth				
£ 70	ation: To	1 Yes 2 No 27. Menner of Death 1 Naturel 5 Pending 2 Accident Investigetic	28a. Dete of Injury (Month, Day Year)	R/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 □ Nursing Hor y at k? Yea 2 □ No		lence 8 ☐Othe		
within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not 4 Homicide determine		ne, lerm, stree	et, fectory, office	1	281. Location (S City or Tox	Street end Numbe m, State)	er or Rural	Route Number,
• Funer lately fill	edical		hyelclen: To the best of my knowl miner: On the basis of examinetio end menner steted.							
withir To th comp	Me	29b. Signeture end title of certifier	~ Mo		29c. Licens	e number		29d. Date signed		
					00			SEPTEME	SER I	J, 1998
		30. Name and address of parago who	completed cause of death (Item 5	23e) (Type Pe	rint)					
		30. Neme end eddress of person who J. LEE KRANTZ, 1				MONT, MD	21788			



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama /First Middle Last) 2. Data of Death 3. Tima of Death September Da **Physician** 920 Mae Esther Heisler /Medical 4a. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County E1kton Ceci1 7. Aga (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Numbar Birthplaca (Stata or Foreign Country) **Funeral** 1□ M 2X F Yrs. 166-16-1574 Director 83 October 24, 1914 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 10d. Insida City Limits 1 ☑ Yas 2 ☐ No Director Maryland Cecil Charlestown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 132 Market Street 21914 United States 11. Maritel Status 12. Was Decedant Ever in U,S. Armad Forcas? Was Dacedant of Hispanic Origin? (Spacify Yas or No-if Yes, specify Cuben, Maxicen, Puarto Rican, etc.) 14. Race - Amaricen Indian, Black, White, etc. 1 Yas 2 No 1 Navar Marriad 2 Married 1 Yes 2 No Spacify: White by 3 ₩idowed 4 Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Educetion (Specify only highast grada completed) 16b. Kind of Businass/Industry Hygiane. Elamantary/Sacondery (0-12) Collega (1-4or 5+) 276 12 Clerk Grocery Store 7 la marked other traumatic event, 17. Fether's Neme (First, Middle, Last) permit. Pages 1 end 2 should be filt.
Department of Health end Mental Hy
Important: If Itam 27 Ia marked oth
any Injury or other traumatic event 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Lawrence Cloud Sara Jessie Cox 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 731 Maryland Avenue, Wilmington, DE 19805 Harry M. Heisler, Jr. / Son 20a. Mathod of Disposition 20b. Place of Disposition (Nema of cematary, crematory or other placa) Data 20c. Location - City or Town, State Sept 14 1 ☐ Burlai 2 XCramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) R. A. Ferris Crematory 1998 West Chester, Penna. 21. Signature of Funeral Service License 22. Name end Addrass of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901 23 Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or haert failure. List only one cause on each line. Approximate Intarval Between Onset end Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) Examiner Exami Saquantially list conditions, if eny, laading to immediata ceusa. Entar Underlying Ceusa (Disaasa or injury that initiated events rasulting in daath) Last Physician/Medical Due to (or es a consequance of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No by 24b. Wara eutopsy findings availabla prior to complation of cause of deeth? director, pege 2 should Completed 24a. Wes en eutopsy performed? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No. Be 25. Was cesa rafarrad to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatiant 2 ER/Outpetient 3 DOA 2 1 Yes 2 No 28a. Date of Injury (Month, Day Yaar) 27. Mannar of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding after death. 1 ☐ Yas 2 ☐ No Investigation 2 Accidant 6 ☐ Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 281. Location (Street end Number or Rural Routa Numbar, City or Town, Stata) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physicien: To the best of my knowledge, deeth occurred et tha tima, data and place, and dua to tha causa(s) end manner as steted.

2 Medical Exeminar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, date end place, and dua to tha causa(s) end mannar statad. edical 29a Cartifian 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) Crelida & Mis 30. Nama and eddrass of person who complated cause of death (Item 23a) (Type, Print)

SACHDEN MD, 118 North St Stute 3B, ELKTON MD 2/92/. 32 Ragistrar's Signatura 31. Data filed (Month, Day, Year) State SEP 1 5 1998 Registrar

DHMH 16 Rev 6/95

or Attending Physician:

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To the

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filed within 72 hours aftar

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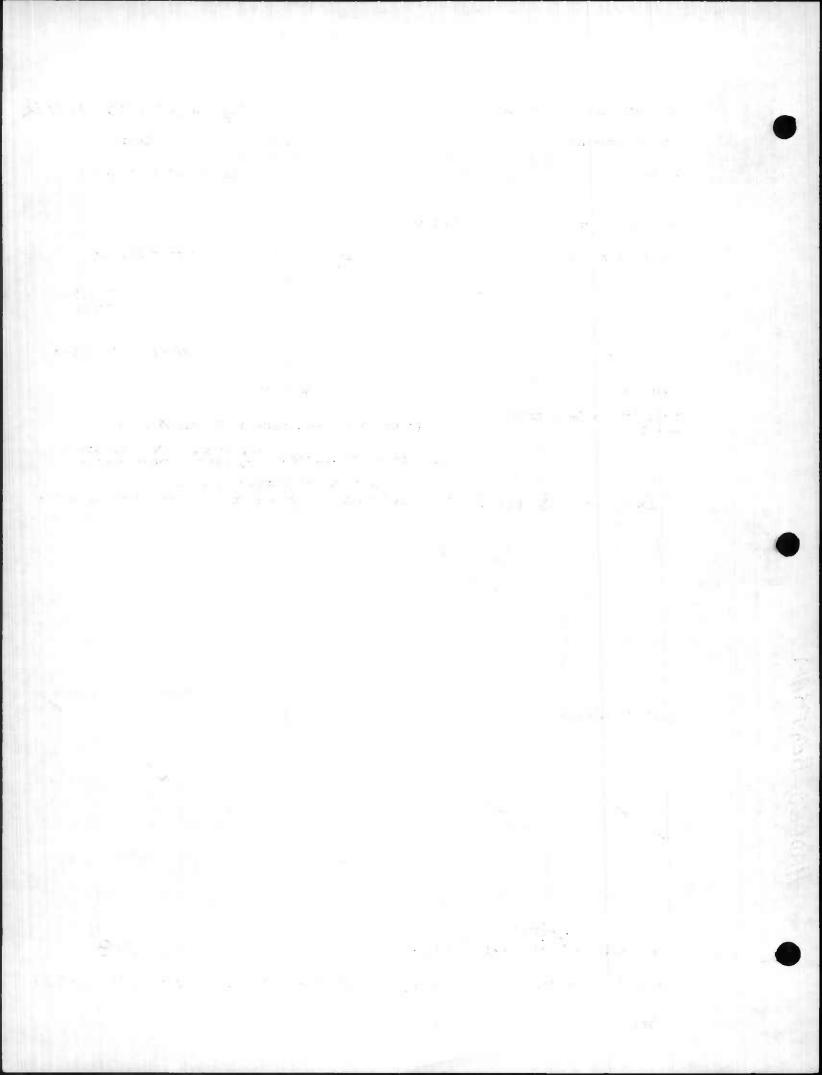
Baltimore, Maryland

for

State of Maryland / Department of Health and Mental Hygiene

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١.	/Medic Examir		4e. Fecility Neme (If no.			nber)				4b. City, Town, or	Location of Death	4c. Coun	ity of Deeth	11/0
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	d within 72 hours effer death with the Maryland ilene. Then "natural", or items 23a or 28a-f show the Modical Example must be notified at	Funeral	11. Maritel Status		12. Wes Dece	dent Ever in	J,S.			lispenic Origin? (S en, Mexicen, Puerl	pecify Yes or No	14. Re	ece - Americ	
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	e filed within 72 hours al Hygiene. other than "natural", vent, na Mooice Ex	Completed	Elementary/Seconder	ry (0-12)	College (1	-4or 5+)	1	ife. DO NOT	use retire	d)		Progra	occ Ti	ghting
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בים	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If item 27 is marked other tt any injury or other traumatic event, m once.		20a. Method of Disposit				Plece of D	Disposition (No	eme of		Dete	20c. Location	- City or To	
Ĕ	Page nent int: If		1 ☐ Buriel 2 ☐ Co			R .		rris a			September 1998		st Che sylva	
altimore	mit. partm porta y inju		21. Signature of Funera	I Service Licer	isee			22. Name :	nd Addre	ss of Facility				
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	/Medical Examiner		Immediete Ceuse (Fine diseese or condition	N .	So	EPSI	15							
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5	After After funer	ion		Pending		h, Day Year)	28b. Tin		28c. Injur Wor	yet k? Yes 2 □ No	28d. Describe h	ow Injury occu	irred	
0	deatl deatl ctor: y the	lical	2 ☐ Accident 3 ☐ Suicide 6	investigation Could not be		of Injuny - At I	ome farm	n, street, fecto		165 2 100	28f Location /5	Street and Num	her or Rura	I Route Number,
2	after after Directory	Certification:	4 Homicide	determined	buildin	ng, etc. (Spec	fy)	, 311001, 10010	19, 011100		City or Tou	n, Stete)	100, 0, 110,2	rroute rumber,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	- 1	29a. Certifier	Certifying Ph	yaiclan: To the I	best of my kn	owledge, d	death occurre	d et the tir	ne, dete end plece	, end due to the	ause(s) end n	nenner es st	eted.
	n 24 l	edical	(Check only 2 one)	Medicel Exam	iner: On the be end mann	sis of examin	etion end/	or Investigatio	n, in my o	pinion, death occu	rred et the time,	dete end place	, end due to	the ceuse(s)
	To the To the comp	M	29b. Signature and title	of certifier	-		1	25	c. Licens	e number		29d. Dete sign	ed (Month, I	Day, Year)
			Na	171	hydre	N	1>					9/11	198	3
	4		30. Neme and eddress of				m 23e) (Ty	ype, Print)		1. 1 0				
			MARC	Sch	neine.	5	22.	3 W	MI	HN ST	EZK	TON	MO	21921
			31. Dete filed (Month, D			egistrer's Sign								

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middia, Last) **Physician** 1998 SEPT. 8 11:45 pm JOHN HENSON /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner ARUNDEL CHESAPEAKE HEALTHCARE ANNE ARNOLD If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplaca (Stata or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12 M 2□ F Mary land Yrs. 219-30-0076 Director 64 OCT. 26 1933 Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural; or items 23e or 28=1 show ary or other traumetic event, the Manical Examinating the notified. r 28a-f show 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Yas 2 No Directo MARYLAND ANNE ARUNDEL GLEN BURNIE 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number Funeral 121 E. FAYWOOD COURT 21060 US 12. Was Decedent Ever in U,S. Armad Forcas? 1 ∐Yes 2 □ No It Yes, Giva Yaar or Dates: KOREAN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK à 3 NWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION SELF EMPLOYED 8th 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middla, Last) GEORGE HENSON CHRISTINA 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CAROL GROSS (DAUGHTER) 1152 GWYNNE AVE. CHURCHTON, MD. 20733 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or DDCe. 4 ☐ Donation 5 ☐ Other (Specify) CALVARY CHURCH CEME. 9/14/98 ARNOLD, MD. MT. 21. Signatura of Funeral Sarvica Licensae WM. REESE & SONS MORTUARY, P.A. Harry D, Xeese 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** hepatic encephalopathy alcohol cirrhosis of the /Medical Immediate Causa (Final 3 months disease or condition resulting in death) Examine Examiner physicien end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequanca of) Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the cause of death? been signed by the should be deteched 1 Yee 2 No 3 Probably 4 Unknown hypoalbuminemia by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy Completed anasarca and hypotension irector, page 2 1□ Yes 2 No 1 □ Yes 2 □ No Hospital or Attending Physician:
 A hours efter death.
 Funeral Director: After this certifice etely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Daath 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eff To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9.10.98 21012 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Blvd ArnoldMD BAA

Registrar

32. Register's Signatura 31. Date filed (Month, Day, Year) SEP 1 1 1998

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

4 4-2 2 ST 411 15 19 16 all Years to a more closed as mill Year, of

State of Maryland / Department of Health and Mental Hygiene

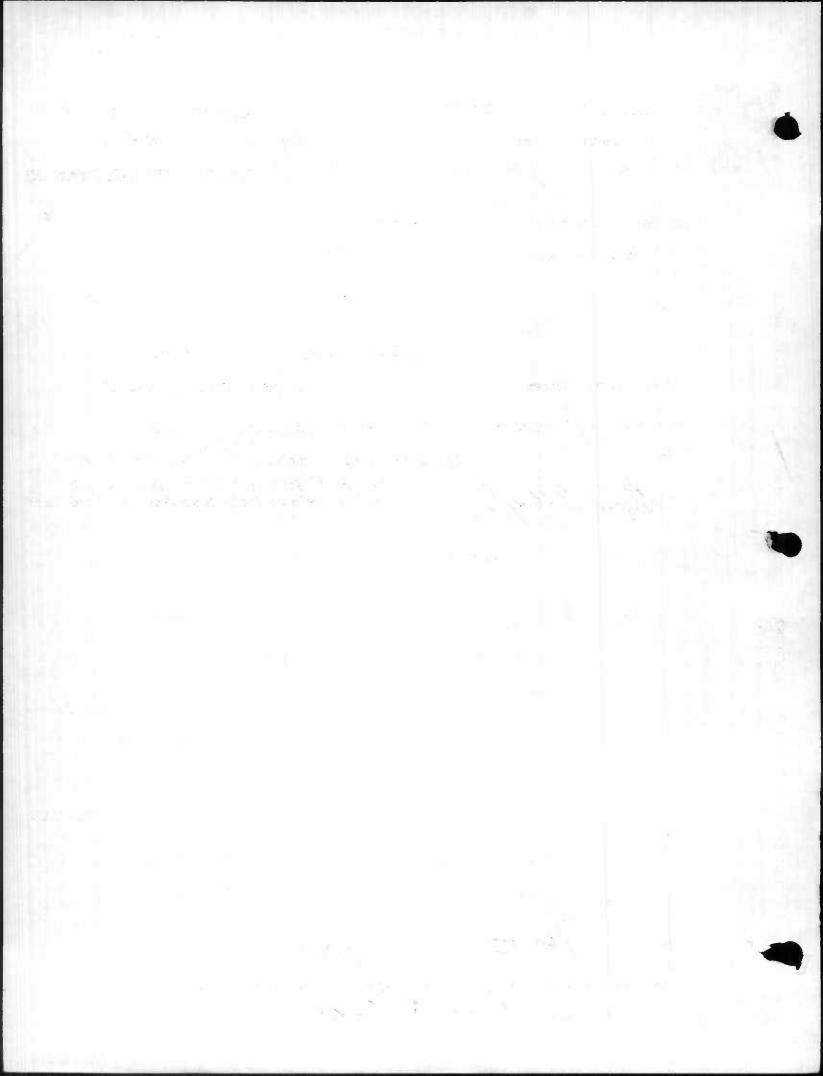
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	-	BESSIE B	ERTHA HO	LLOWAY	Z			Month Serter	nber 6.	1998	4:50 AM
/Medica		4a. Fecility Neme (If not Institution, give					4b. City, Town,	or Location of Dee		y of Deeth	1100 111
		1911 Conowingo R	oad				Bel	Air	На	rford	
Funeral Director		5. Sociel Sacurity Number 227–16–7434 Usual Residence of Decedant	Sax I□M 215 F 7. A	ge (In yrs. la 80	ast birthday) Yrs.	If Under 1 Ya		Vin. (Month, D	irth Pay, Year)), 1918	9. Birthr Cour Vir	place (State or Foreigntry) ginia
ž ==		10e. State 10b. County		10c. City	, Town or Lo	cation				1	Od. Inside City Limit
28a-f show	tor	Maryland Har	ford	E	Bel Air	c					1 ☐ Yas 2 ☒ N
23a or 28	Funeral Director	10e. Street and Number 1911 Conowingo Ro	oad			10f. Zlp Coo	1014		10g. Citizen of US		ntry?
one. than "natural", or items 23e or 28e-1 show fre Medical Examiner must be nomined at	by Funer	11. Marital Stetus 1 ☐ Nevar Merried 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	12. Wes Decedent Armed Forces 1 Yas 22 If Yas, Giva Yaar or Dates:	Evar in U,S ? No			of Hispanic Origin' Cuben, Maxican, P No Specify:	7 (Specify Yes or Nuerto Rican, atc.)	o- 14. Ra Ble Speci	ce - Amaric eck, White,	
f Health and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event, the Medical Exc	Completed by	15. Decedant's E (Specify only highest gra Elementary/Secondery (0-12)	ducation ade completed) College (1-4or	5+)			cupetion one during most of tired)	working	16b. Kind of E		·
d other te		17. Fathar's Nama (First, Middla, Last,	1		Home	emaker	18 Mother's	Neme (First, Middl		n Hom	e
and Mental Hygiene. s marked other than summit event, the M	To Be	John Fielder	Sexton				Sarah			Fine	
marke umatic	F	19e. Informent's Name/Relationship (Type, Print)		19b. Mellin	g Address (Str	eet end Number o	r Rural Route Num	ber, City or Town	n, Steta, Zip	Code)
aith ar 27 is or trau		Christine J. Hol	loway-Daug	ghter	1911	Conowi	ngo Rd.,	Bel Air	, MD 21	014	
of He r oth		20e. Method of Disposition 1 ⊠ Burial 2 □ Cramation 3 □	Bemauel from State	0.0	ece of Dispo	sttlon (Neme of netory or other	(plece)	Date	20c. Location	- City or To	own, Stata
ant: H		4 Donation 5 Other (Specif			k Run	Cemete	ry	9/10/98	Havre	de G	race, MD
Depertment of Health a important: If hem 27 is any Injury or other tragence.		21. Stagetura of Funerel Service Licer	MC A	2000	He	oward K		s III Fur		me, P	.A.
		23a. Pert1. Enter the disease, or com shock, or heert failure. List only	plications that causa	d the deeth.	Do not ente	or the mode of	dylng, such es cer	, Bel Air	errest,	1014	Approximate Interval Between
hysician /Medical xaminer	Examiner	Immediate Ceuse (Finel disease or condition resulting in death)	· Card			1	tory,	Amest nal G	an (e)		2 month
the attending physician and thed for use as the burial-transit	edical Exa	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseesa or Injury that initiated events resulting in deeth) Last	С.		as a consequence of a c						
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signed by the	by Physician/N	Part II. Other significant conditions of VII B12	ontributing to death to Defic		-	derlying cause	given in Part i.		Yes 2		the cause of deat
s been 2 shou	Completed b							24e. We per	s en eutopsy formed?	av co	ere autopsy findings allable prior to mpletion of cause death?
	COL							10	Yes 20 No	10	Yes 2000
certificata rector, pag	Be	25. Wes cese referred to medical examiner?						Deeth (Check only	one)		
r this certific	5	1 Yes 2 No	Hospitel: 1 Inpati		R/Outpatien	1 3LI DON		ng Home 5 Res			(y)
effar daath. Director: Affar is in by the funer.	ation:	27. Menner of Death 1 Neturel 5 Pending investigation		ay Year)	28b. Time of Injury		njury et Work? 1 □ Yes 2 □ No	28d. Describe	how injury occu	rred	
within 24 hours efter death. To the Funeral Director: After thi complately filled in by the funeral	Certification:	3 Sulcide 6 Could not be determined	289. Piece of in	jury - At hor tc. <i>(Specify)</i>	ne, ferm, stre	et, fectory, offi	ice		(Street end Num own, State)	ber or Rure	el Route Number,
0 2 = 1	edical		ysician: To the best niner: On the basis of	of examination							
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thin 24 P	Š	29b. Signeture and title of contition				Z9C. LIC	ansa numbar				Dev. Year)
within 24 hours effa To the Funeral Dirac complately filled in	Me	29b. Signetura and titla of certifier	M			D (8424		SEPT.		

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Certificate of		F	Reg. No.	3 29347
Physic		1. Decedent's Nama (First, Middle, Last ARBUTUS (N		WELL			2. Date of Dea	Day 7	Year 98 /1:15 P
/Medi Exami		4a. Facility Name (If not institution, giva	m wal	1555		4b. City, Town, or L	ocation of Death	4c. County	
		Stella Maris Hosp	pice			Timoniu	ım	Bal	timore
Funeral Director	_	5. Social Security Number S. S 217-36-3491	The order	(In yrs. last birt	thday) If Under 1 Year Months Days		8. Date of Birth (Month, Day June 22	r, Year)	9. Birthplaca (State or For Country) North Caroli
yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Lin
Ba-f.s.	Director	Maryland Harford	£	Ch	urchville				1 ☐ Yes 2%
with th	Dire	10e. Street and Number 2905 Grafton Lar			10f. Zip Code	200		10g. Citizan of V	
leath	Funeral	11. Marital Status	12. Was Dacedent Ev	ver in U.S.	210		ecify Yes or No-		SA e - Americen Indian,
filed within 72 hours effer death with the Maryland Hygiene. thysiene. ther then "natural", or items 23s or 28s-f show ent, the Medical Examiner.	by	1 □ Never Married 2 □ Marriad 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:		13. Was Dacadent of If Yes, specify Cub 1 ☐ Yes 2 ☒ No		Ricen, etc.)	Specify:	k, White, etc.
be filed within 72 hours of that Hygiene. Id other than "netural", or event, the least than "netural", or event, the least terms.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucetion le completed) College (1-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work ed)	ing		sinass/industry
Hygier ther ti	Co	17. Father's Nama (First, Middle, Last)		Ca	feteria Wor	18. Mother's Nam	o /First Middle	Educat:	
8 4 5 5	To Be	John Andrew Gent	try			Margare		hia Cai	
d 2 should be file th end Mental Hy 7 is marked oth traumatic event	-	19a. Informant's Name/Relationship (7)	ype, Print)	19b.	Mailing Address (Stree				
1 end 2 Health e em 27 is	H	Martha H. Oaks/ Da	aughter	21	0 Acorn Dr.	, Middlet	own, DE	19709	
		20a. Method of Disposition Burial 2 Cramation 3 F		cemeter	Disposition (Nama of y, crematory or other pla		9-10-98		City or Town, State
permit. Pages Depertment of Important: If if any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens		Oak GI	ove Baptist	100			r, Maryland
permit. Depertriments any inject.		Alsh a.	Augh	to death. Do	1317 Cc	okesbury F	Road, Ab.	ingdon,	Home, P.A. Maryland 210
Physician /Medical Examiner		Immediate Cause (Final disease or complete of the control of the c	ne callse on each line Bone C					001,	Approximate Interval Between Onset and Death
	e.	resulting in death)	D	ue to (or as a c	onsequence of):				
tificate be executed g physician end es the bural-transit	edicai Examiner	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury	b	ue to (or as a c	onsequence of):				
artificate be ex ing physician e es the burial	907	resulting in death) Last	C	ue to (or as a co	onsequence of):				
eath cert ettendin I for use	ian/		1.						
that the deaded by the e	Physician/	Part II. Other significant conditions con	ntributing to death but	not resulting in	the underlying ceuse gi	ven in Part I.			tribute to the cause of de
es that the digned by the	by P						101	as 2□No	3 ☐ Probably 4 ☐ Unkr
aw requir	Completed						24a. Was a perfor	an autopsy med?	24b. Were autopsy findin available prior to completion of ceuse of death?
	Com						1 🗆 Y	es 2K No	1 ☐ Yes 2 ☐ No
ician: The	Be	25. Was cesa referred to medical examiner?	12-1			26. Place of Deat	h (Check only or	10)	
Phys ral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	dospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)	2 ER/Out 28b. T	ime of ijury 28c. Inju		me 5 Resid 28d. Describe h		er (Specify) HOSPIC ed
ai or Attanding s after death. il Director: After ed in by the fune	Certification:	3 Sulcide 6 Could not be 4 Homlcide determined	28e. Place of Injury building, etc.	y - At home, far (Specify)	m, streat, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in	edical (29a. Certifier (Check only one) 1 ☐ Certifying Physical Examination (Check only one)	sician: To the best of ener: On the basis of eand manner state	xamination and	death occurred at the ti Vor Investigation, in my	me, date and place, opinion, death occurr	and due to the cred at the time, d	ause(s) and mai late and place, a	nner as stated. Ind due to the cause(s)
To the Comple	Me	29b. Signatura and the of certifier	3 4		29c. Licans	se numbar	2	9d. Date signed	(Month, Day, Year)
		1	17		7)43	3725	19	e skenhe.	8,1998
18		30. Name and addrass of person who co	impleted cause of dea	th (Item 23a) (Type, Print)			porton	411
		DR. TARIQ MAHMOO			VALLEY RD.	TIMONIUM	, MD 21	093	
Sta Regist		31. Data filed (Month, Day, Year)	32. Registrar		South	,			

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Winona M. Hutchison September 9,1998 10:00PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 1□ M 2⊠ F Months Vrs 89 481-07-3477 May 30, 1909 Montana Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7927 Mandan Road, #T-3 U.S.A. 20770 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Spacify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: by Specify: 3 Widowed 4 □ Divorcad White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Department Elementery/Secondery (0-12) College (1-4or 5+) Editor of Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) John Mail Lucy Koon 19e. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8803 Cunningham Drive, Berwyn Heights, MD Donald Hutchison - Son 20740 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 9/12/98 Brentwood, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Gasch's Funeral Home leny 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feiture. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a conseque Physician/Medical Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Renal Insufficiency þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? meson cà 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Naturel 5 Pending 1 Tes 2 No Investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 9/10/98 22/11 com 30. Name and addless of person who completed cause of death (Item 23a) (Typa, Print) LUCK ROAD, LANHAM, MD 20706 THOMAS KO MO
31. Date tiled (Month, Day, Year) 8100

32/Registrar's Signature

Horse

State Registrar

SEP 1 1 1998

Funeral

Director

a zea-f show

b must be Items 23a

"natural", or

and Mental marked

Department of Health a important: If Item 27 is any injury or other tra

Physician

/Medical Examiner

physician and s the burial-trans

signed b

altimore,

Box 68760.

P.O.

Records,

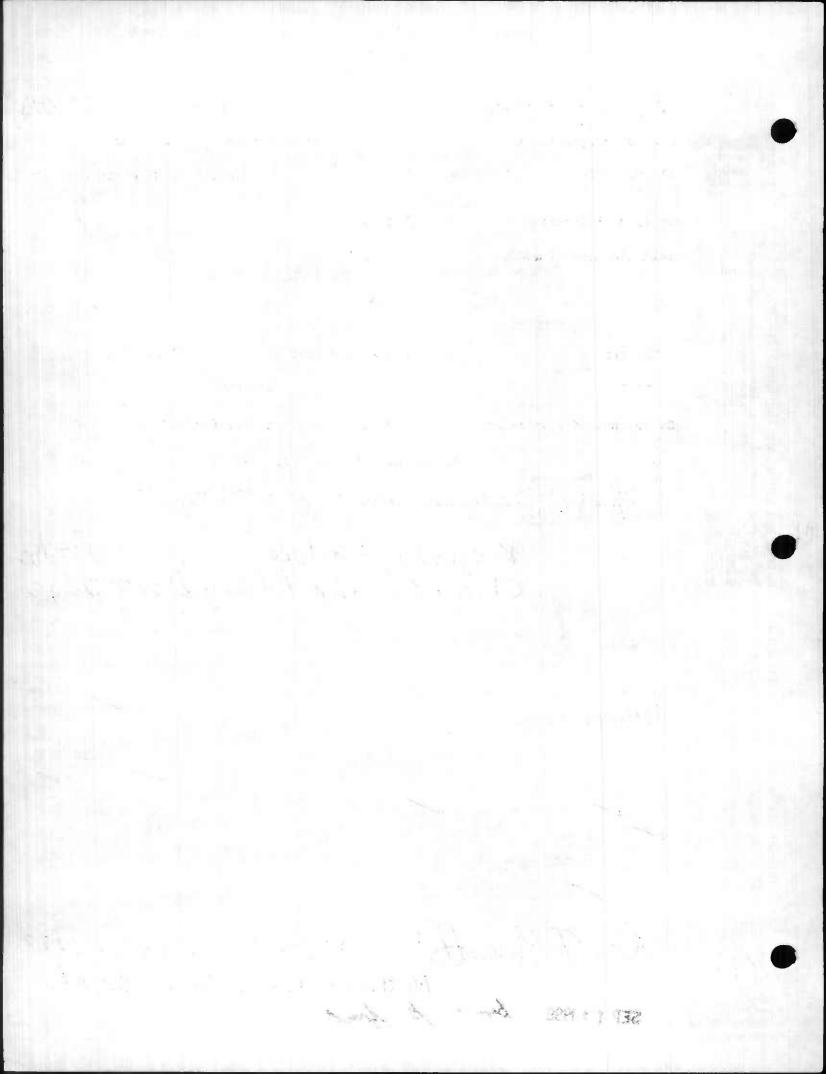
Division of Vital

or Attending Physician; after death. Director: After this certifica

To the Hospital or within 24 hours aft To the Funeral Dis completely filled in

State of Maryland / Department of Health and Mental Hygiene 9 9 9 9 5 5

		Certificate of Death	Reg. No.
Discolation	Decadent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death
Physician /Medical	Daisy Horne		Nugust 24, 19925 - AM
Examiner	4a Facility Name (If not institution, giva street and number)	4b. City, Town, or L	ocation of Death 4c. County of Death
	Northwest Hospital Center	Randallst	own Baltimore
Funeral	5. Social Security Number 6. Sax 7. Aga (In yrs.	Months Davs Hours Min.	8. Data of Birth (Month, Day, Year) 9. Birthplace (Stete or Foreign Country)
Director	217-05-6888A 97	Yrs.	Jan. 9, 1901 North Carolina
2 >	Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ty, Town or Location	10d. Inside City Limits
show			1√2 Yes 2 □ No
the Meryle 28e-f sho norm of rector		ndallstown	4
Dir Sor I	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
aryland 21215-0020 should be filed within 72 hours effer death with the Meryland at Mental Hygiene. marked other than "natural", or items 23s or 28s-f show urretic event, the Medical Estate field must be notified. To Be Completed by Funeral Director	5412 Old Court Road	21133	USA Pecity Yes or No- 14. Race - American Indian.
items items	11. Marital Status 12. Was Decedent Evar in U Armed Forces?	I,S. 13. Was Decedant of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) Black, Whita, atc.
20 rs eft	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, Give 1 Yes, Give 2 Year or Dates:	tXXYas 2□ No Specify:	Specify:
ind 21215-002(be filed within 72 hours e lei Hygiene. d other than "natural", o went, the Marie Exert Be Completed by	15. Decedent's Education	16e Decedent's Usual Occupation	mbian Black 16b, Kind of Business/Industry
21215-0020 d within 72 hours ef glene. wrthan "natural", or fre wester from Th	(Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	king
with with there.	Elementery/Secondary (0-12) College (1-4or 5+) Unknown	Domestic Worker	Private Industry
o street	17. Fathar's Name (First, Middla, Last)	18. Mother's Nam	na (First, Middla, Maiden Sumame)
Maryland d 2 should be file th and Mentel Hy 7 is marked othe traumatic event.	Jones	Unk	nown
Maryland 212 d 2 should be filed with hand Mentel Hyglene. T is marked other than treumatic event, the urenterm treumatic event, the urenterm To Be Comp	19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru	ral Routa Number, City or Town, State, Zip Code)
Ce, Marine 1 end 2 Health e am 27 is	Carlos Hutchins/grandson	3193 N.W. 40 Street.	Ft. Lauderdale, FL 33309
iore, Maryland 212; ges 1 end 2 should be filed within t of Health end Mental Hyglene. t of Health end Mental Hyglene. if item 27 is marked other than or other traumatic event, the M To Be Comp	20a. Method of Disposition 20b. I	Place of Disposition (Name of cematery, crematory or other place)	Date 20c. Location - City or Town, Stata
Pages nent of Indi: If Ite	1 Burial 2 Cremation 3 Removal from Stata		3/31/98 Washington, DC
프 교원경상	21. Signature of Funoral Service Licenses	22. Nama and Address of Facility	noningeon, bo
Ball Depariment	1 4-1 4- K	Lincoln & Lincoln	Funeral Service ., NE Wash., DC 20019
	23a Part Entrine disease, of complications that caused the dear	th. Do not enter the mode of dving, such as cardiac	cor respiratory arrest, Approximete
Physician	shock, dones failure. List crity one cause on each line.		Interval Between Onset and Death
/Medical	Immediate Cause (Final	Fail.110	11/2 h
Examiner	disease or condition resulting In death) a.	or as a consequence of):	1 /2/1/
le le	Chroni	- Obdartive Pulm	DIRECT DISPOSE TOUR
60, be executed lotan end buriel-transit	Sequentially list conditions.	or as a consequence of):	way bishist a coli
O, exe	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury		
Sys ate		or as a consequence of):	
K 68			
Boy eath ce ettendi for use	d		
, P.O. BO) that the death ce ed by the ettendi detached for us.	Part II Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death
P.O at the at the etache	Deman Lis		1 Yes 2 No 3 Probably 4 Unknow
es tha igned be de be de by P	OF WENT 10		
/ital Records, P.O. Boy slan: The law requires that the death cantificate has been signed by the ettend ector, page 2 should be detached for us. Be Completed by Physician/			24e. Was en autopsy performed? 24b. Were autopsy findings aveileble prior to
Reco			completion of cause of death?
The The Page			1 Yes 20 No 1 Yes 20 No
r Vital Re relation: The la secretificate he director, page To Be Com	25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)
of Vital Records, Physician: The law requires the this certificate has been signed rail director, page 2 should be continued.: To Be Completed by	1 ☐ Yas 2 ☐ No Hospital: 1 ☐ Inpatient 2	ER/Outpetient 3 DOA Other: 4 Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
ding Pi After th funera	27. Manner of Death 1 Netural 5 □ Pending (Month, Dey Year)	28b. Time of lnjury at Work?	28d. Describe how injury occurred
Attending or death. ector: After by the fune	2 Accident investigation	M 1 Yes 2 No	
Division or Attending after death. Director: After d in by the fune ertification	3 ☐ Suicida 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
tal or rai Dir			
Division of Northe Hospital or Attending Physicathin 24 hours after death. To the Funeral Director: After this of completely filled in by the funeral director. Medical Certification: To	(Check only 2 Medical Examiner: On the basis of exemina	owledge, death occurred et the time, date and place atlon and/or Investigetion, in my opinion, death occu	a, and dua to the cause(s) and manner as stated. Befored at the time, date and place, and due to the cause(s)
Within 2. To the F complet	one) and manner stated.	^	
S S S S S S S S S S S S S S S S S S S	29b. Signatury and title of certifier	29c. Licansa number	29d. Date signad (Month, Day, Year)
E	Marine Collaborator	D 35906	Hugust 24, 1778
(4)	30. Name and address of person who completed cause of death (Ite	m 23a) (Type, Print)	161 711 40
	Daniel Malone, M.D.	Northwest Hospit	al Center Balt. M.C.
State	31. Deta filad (Month, Day, Year) 32 Registrar's Sign	ature	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth **Physician** SEPT. RICHARD M. HANSEN 3, 1998 7:45 AM /Medical 4e. Facility Name (If not Institution, give streat and number, 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY CO. If Under 1 Year if Under 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpteca (State or Foraign Country) **Funeral** Deys MM 2□ F 578-12-0456 82 Director Yrs. JAN.8,1916 WASH., DC Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location a or 28a-f show be notified at 10d. Inside City Ltmlts MD. MONTGOMERY CO. ROCKVILLE Director 1X Yas 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9817- VEIRS DRIVE 20850 "natural", or items 23a USA death Funeral 12. Was Decedent Ever In U,S. Armed Forcas? 1 X Yes 2 □ No If Yes, Give 11. Marital Status Wes Decedent of Hispanic Ortgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Black, Whita, etc. filed within 72 hours after 1 Navar Marriad 2 Marriad 21215-0020 1 ☐ Yas 2 X No Specify: Completed by If Yes, Give Year or Dates: 1942-1946 Specify: WHITE 3 Widowed 4 Divorced The Medical 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Bustness/Industry (Specify only highest grade completed) than Elementary/Secondery (0-12) Hyglene. College (1-4or 5+) ILLUSTRATOR ILLUSTRATION i. Pages 1 and 2 should be filed w tment of Health and Mantal Hygler tant: if item 27 is marked other ti lury or other traumatic event, In 12 Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be ASPEL MAURICE HANSEN JESSIE KNOTT 19e. Informent's Name/Retetionship (Type, Print) 19b. Metling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JUNE HANSEN- WIFE 9817- VEIRS DRIVE, ROCKVILLE, MD. 20850 20b. Ptece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cramatton 3 ☐ Removet from State permit. Page Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) ROCK CREEK CEMETERY 9/8/98 WASHINGTON, DC 21. Signature of Funeral San Licensee 22. Neme and Address of Facility HYSONG CO., INC. t caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest n each line. WASHINGTON, DC Approximete Intarval Between Onsat and Death **Physician** /Medical Immediate Causa (Final disaase or condition resulting in deeth) Examiner Du to (or es e consequence of): The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest and Due to/(or es e consequence of): physician Physician/Medicai accider P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ò Completed 24e. Wes en autopsy performed? 24b. Wera autopsy findings aveilable prior to comptetion of causa of death? this cartificate hes 1 Yas 2 ₩No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case refarred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner Deeth 28c. Injury et Work? Certification: 28b. Time of After t 28d. Describe how tnlury occurred Attending 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident aftar death 6 Coutd not be determined 3 □ Suicide À 28e. Plece of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 D Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and ptace, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mennar stated. edicai (Check only 29b. Signature and titia of certifier 29c. Licanse number 29d. Dete signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) KARESH- 9701- VEIRS DRIVE, ROCKVILLE, MD. 20850 CHARLES W. 31. Dete fited (Month, Day, Year) SEP 0 8 1998 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JAMES DOUGLAS HILL

State of Maryland / D

epartment of Health and Mental	Hygiene	9	28	0,		()	3	5
Certificate of Death	Don No.	427	CI		~	will.	Ų	V

2. Data of Daath 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 7, 1998 aar **Physician** SEPT. 12:23 PM James Douglas Hill /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL O.R. BALTIMORE N/A If Undar 1 Yaar 5 Social Sacurity Number If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Months Hours | Min. 1₩ M 2□ F Days Yrs. Director 29 218-88-9189 Nov 14,1968 Maryland Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at the Meryla 1 Yas 2 No Director Halifax South Boston 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A.

14. Race - Amarican Indian,
Black, Whita, atc. 2021 College St. 24592 Funeral death 12. Was Decedant Evar in U,S. Armed Forcas?

1 Yas 2 No If Yes, Give A Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status pernit. Peges 1 and 2 should be filed within 72 hours efter of Department of Health and Mental Hygiena. Important: if itsm 27 is marked other than "natural", or fier any Injury or other traumatic event, the Medical Examina and any Injury or other traumatic event, the Medical Examina Date. 1 □ Nevar Married 2 □ Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowad W Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa, DO NOT use ratired) (Spacify only highast grada complated) Collaga (1-4or 5+) Elamantery/Secondary (0-12) Laborer Construction 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Jewell Williams Dora Sydnor 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Dora Hill - Mother 2021 College St. South Boston, VA 24592 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 XBuriai 2 Cramation 3 Ramoval from Stata Brown, s Mem Cemetery 9/12 Nathalie, VA. 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funarai Sarvice Licensaa 22. Nama end Address of Facility Central VA Funeral Scv. P.O.Box 26528 Richmond, VA 23261 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, shock, or haen feiture. List only one ceuse on each line. Approximate Intervat Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner physician end the buriel-transit certificate be asscuted Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting In daath) Last Dua to (or as a consequance of): Physician/Medical Dua to (or as a consaquance of): 80 980 ō 23b. Did tobacco use contribute to the cause of death? Pert It. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to complation of causa of death? 24a. Was an autopsy Completed peed has 1 M Yes 2 □ No 2 No 25. Was casa rafarrad to medical Be 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatiant XXER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 10 XIX Yas 2 No this 28a. Data of Injury Month, Day Year) funeral 28c. Injury at Work? 28d. Dascribe how Injury occurred 27. Mannar of Death 28b. Tima of Certification: Black Wedland; Balting 18 August And Number or Rural Routa Number, Black was land and a Balting 18 August And 18 Balting 18 August And 18 Augu Subject 1 Naturai 5 Panding efter death. Director: Aft 10:90 AM 98 Police investigation 2 Accidant 3 Suicida 6 Could not be Piece of Injury - At homa, farm, straat, factory, building, atc. (Specify) 4 Homicida ŏ Street

To the Hospital within 24 hours e To the Funeral C Hospital

> State Registrar

Medical

31. Dete fited (Me th, Day, Year) SEP 0 9 1998

29b. Signatura and titla of certifiar

29e. Cartifiar

(Check only one)

30. Neme and add

026

estaner 111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signatura

ess of person who completed cause of deeth (Item 23a) (Type, Print)

To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) end manner as stated.

**Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated.

29c. Licansa number

O.C.M.E

29d. Data signed (Month, Day, Year)

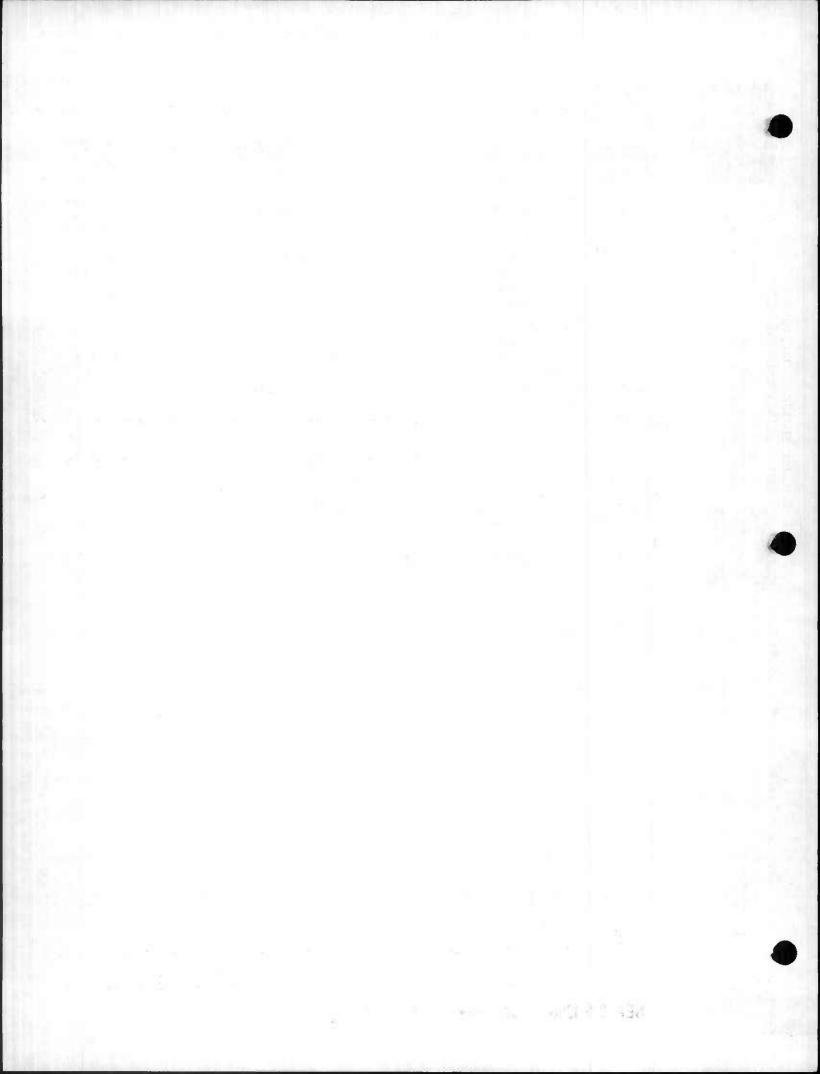
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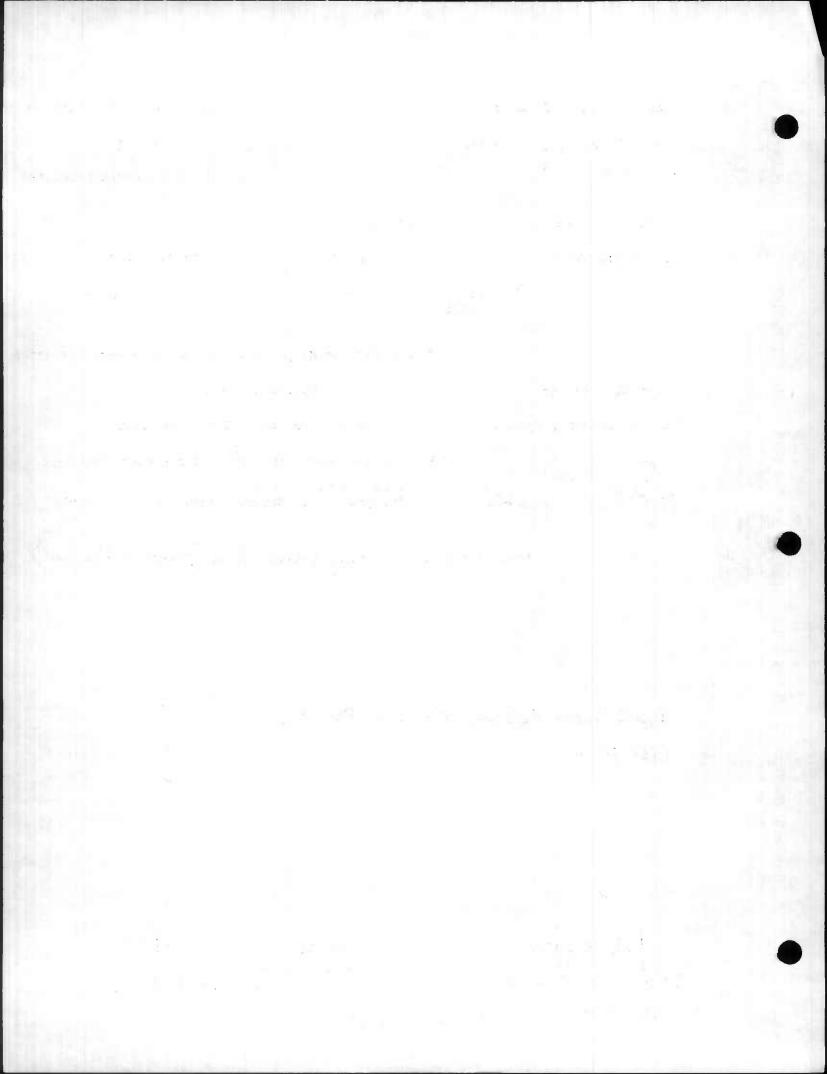
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	1	. Decedant's Name (First, Middla, L	ast)					Death	2. Data of De	Reg. No.		3. Tima of Deeth
ysician	ı		lman						Month	BER 08,	Yaer	00:20 A.M
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neral					last birthday) Yrs.	if Undar Monfhs	Year	CAMP SPI If Undar 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	E GEOR	e (Stata or Foreign
ctor	-	320-34-7418 July Suel Rasidance of Decedent	A	50	115.				Feb 18	, 1940	Missi	ssippi
find at	1	0a. Stata 10b. County Iaryland Prince	George's	10c. Ci	ty, Town or Lo		Jpp	er Marlbo	oro		10d.	Inside City Limits 1 X Yas 2 □ No
unt be notified at rai Director		0e. Streef end Number 7100 Purple Ave	ens Avenue			10f. Zip	Code	20772		10g. Citizen of	Whet Country	?
Daminer in by Funer		Marifel Status Nevar Married 2 Married Widowed 4 Divorced	12. Wes Decedant Armed Forcas 1 Yas 2 If Yes, Giva Yaer or Dafes:	?		Was Decedent Yes, special □ Yes 2		Hispenic Origin? (S an, Mexican, Puart Specify:	pecify Yes or No o Rican, atc.)		ce - Amarican ck, White, etc. y: Blac	
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To E	L	Leroy Cooper	Sr.					Margai	cete Bel	.1		
or trauma	1	9a. Informent's Neme/Ralationship Kyme Holman/Dauc						and Number or Ru Avens Ave				
any injury or other ti	2	0a. Mathod of Disposition 1 1 Bunal 2 □ Cramation 3 4 □ Donation 5 □ Other (Spec			Plece of Disponentary, cremesurrec	natory or of	nar pla		Data 9/11/98	20c. Location -		
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letely filled in	2	9a. Cartifiar TC Cartifying P	hysician: To the best	of my kno	wladga, daath	occurred a	the ti	ma, deta and place	, and dua to tha	causa(s) and ma	annar as state	d.
npletely fill		one)	minar: On the basis of and mannar st	ated.	mon and/or inv				rrec at tha time,			
Me Me	_	9b. Signetura and title of certifier	trans	mo		ОН		e number -07-0341-	-F	29d. Data signe		
/	3	 Nama and eddress of person who THOMAS G. FRASEI 				03		G/1050 W WS AIR FO			0762 66	.00

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						Certii	ficate of	Dealli		Reg. No.		9353
Physici	an	1. Decedent's Name	e (First, Middla, Li	ast)					2. Data of Do Month	eath Day	Year	3. Tima of Death
/Medic		Robert	Dale	Johnson					Septem	ber 13,	1998	10:40 AM
Examir		4a. Facility Name (I	f not institution, gi	ve straat and number)				4b. City, Town, o	Location of Deal	th 4c. County	of Death	
		Calvert 1	Manor Hea	althcare C	enter			Rising	Sun	Co	cil	
uneral		5. Social Security N			e (In yrs. last I		Under 1 Yaar	If Under 24 Hr	s. 8. Date of Bi			ace (Stete or Foreig
rector		214-18-2	157	1⊠M 2□F	77	Yrs.	lonths Days	Hours Mir	May 21			(y) Carolina
		Usual Residence of							may 21	, 1921	NOT CI	Calullia
NO THE		10a. State	10b. County		10c. City, To	wn or Locati	ion				10	d. Inside City Limit
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0 8	ā									rog. Citizen of v	rviiat Count	iry r
23	ral	112 Willa	ard Drive				21901			United		
E J	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?		13. Was	Decedent of I es, specify Cub	Hispanic Orlgin? (an, Mexican, Pue	Specify Yas or Norto Rican, etc.)		e - Amarica ck, White, e	
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important; in fam 27 is marked other train maturally any injury or other traumatic event, the Medical once.	Be	17. Fether's Name (18. Mother's Na	ame (First, Middle	, Maiden Sumem	10)	
atic	2	Robert G	len Barke	er				Maggie	Johnson			
raum		19a. informent's Na	me/Reletionship	(Type, Pnint)	15	9b. Mailing A	ddress (Street	t end Number or F	Rural Route Numb	er, City or Town,	State, Zip	Code)
Z L		Etta A.	Johnson	/ Spouse	1	12 Wi	llard I	rive, No	orth Eas	t. MD 2	1901	
other to		20e, Method of Disp			20b. Place	of Disposition	on (Neme of		Date	20c. Location -		wn, State
Important: If its any injury or ot once.				Removal from State			ory or other pla		Sept. 17			
, S		1	5 ☐ Other (Speci	-	North	-		ist Cem.	1998	North Ea	ast, N	Maryland
any ir		21. Signature of Fu	neral Service Lige	hispe //	7	Cro	ame and Addra	ass of Facility neral Hor	ne			
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-		23a. Part 1. Enter th		Carried Contract				Main Sti	reet No			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Dey **Physician** 1998 PEARL JOHNSON SEPT. 5:20 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1175 MADISON STREET APT. A4 ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Yrs. Director 75 217-16-7438 Usual Residence of Decedent MARCH 11 1925 MARYLAND the Maryland 10d Inside City Limits r 28a-f show incitied at 10a State 10b. County 10c. City. Town or Location Yes 2 No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with "natural", or itams 23a or 1175 MADISON ST. APT. A4 21403 IIS Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: 14. Rece - American Indian. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced r than "nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 0 7th LAUNDRY DEPT. FT. GEORGE MEADE 7 is marked other traumatic event, i 18 Mother's Name (First Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Pages 1 and 2 should be filt ment of Health end Mental Hy ant; if item 27 is marked oth ury or other traumstic event Be GEORGE McGOWANS FANNIE DOWNS 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 803 A. BROOKE COURT ANNAPOLIS, MD. 21401 PEARL ELDRIDGE (DAUGHTER) 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If sny injury or once. HILL CREST CEMETERY 9/9/98 ANNAPOLIS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. Leesa Harry 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) Examine Examiner physician and the buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) attending pl signed by the a Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? P 24a. Was an autopsy performed? Complet iis certificate hes h director, pege 2 s 1 Ves 2 WNo 1 Tyes 2 No Attending Physician: 25. Was case referred to medical Be 26. Placa of Death (Check only one) exeminer? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 1 Yes / 2 No Certification: To this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Minatural 1 ☐ Yes 2 ☐ No death. Investigation 2 Accident or Attended effector: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour.
The Funeral Direction by 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Dato highed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number bordd 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tonter Breit Analys MD C. ROANE, 16/6 31. Date filed (Month, Dey, Year) SEP 0 9 32. Phoistrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1 Decedent's Nama (First Middle Last) 2. Data of Death **Physician** 31, 1998 TONES RODGER CROZIER Aug. 10:58PM /Medical 4e Fecility Neme (If not Institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 6. Sax 1 M 2 □ F 5. Sociel Sacurity Number Birthplace (State or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 213-22-1289 Yrs. Director 86 July 16, 1912 Maryland Usual Rasidance of Decedant the Marylenc 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 21403 120 Sunset Drive death Funeral 12. Wes Decedant Evar in U,S Armed Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxicen, Puarto Ricen, atc.) 14. Race - American Indien. Bleck, White, atc. 2 should be filed within 72 hours efter and Mental Hygiene.

Is marked other than "naturel", or its 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dates: 1 Navar Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Specify: White À 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16e. Decedant's Usual Occupation
(Giva kind of work dona during most of working lifa. DO NOT use retired) 16b Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Electrical 11 Master Electrician 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Esther Catherine Crozier Charles Clinton Jones 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 sh Depertment of Health end Important: If Itam 27 le m any Injury or other treum page. 1816 Millridge Court Annapolis, Md. 21401 Vicki Robertson (Niece) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Cremation 3 Ramoval from Stata
4 Donation 5 Othar (Specify) 9/4/98 Cedar Bluff Cemetery Annapolis, Md. 22. Nama and Addrass of Facility John M. Taylor Funeral Home Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause cations that caused the deeth. Do not enter tha mode of dying, such as cerdiac or raspiratory arrest, Onsat and Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) Examiner Sequantially list conditions, if any, leading to immediata ceusa. Entar Undarlying Cause (Diseasa or injury that initiated avants resulting in daath) Last buriel-tran Dua to (or as a consequence of): and certificate be exec P.O. Box 68760. physician Physician/Medical the Due to (or as e consequança of): 80 use for 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. the Hislase 6 1 Yes 2 1 M6 3 Probably 4 Unknown PV Division of Vital Records. 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Completed completion of cause of death? certificate hes 1 ☐ Yas 2 ☐ No or Attanding Physician: 25. Was case ratarred to medical axaminer? Be 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending invastigation efter death. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homicida Hospital c 24 hours e Funeral D 29a. Cartifian 1 🔏 Certifying Phyaician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated. edical 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. (Check only one) within 2 94 29b. Signature and titla of cortifu 29c. Licanse numbar 29d. Data signad (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) 201 RIDGELY AVE DUNDROLLI, MO 2,401 LICHTEN STEIN MD 31. Date filed (Month, Day, Year) 32. Aegistrar's Signatura State SEP 0 8 1998 Registrar

DHMH 16 Rev 6/95

= 1 Sed 8 1950

AMmended Harford County Health Dept. Line 26 9/10/98 KDG Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Tima of Death **Physician** September 5, 1998 EDWARD PURNELL JACKSON. SR. 0032 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Harford Memorial Hospital Havre de Grace Harford | Funder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 26, 1923 If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Yrs 75 212-20-6231 Director Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nas 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 늄 605 Idlewild Rd. 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, atc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) Management Analyst U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Nelson Levon Turner Carrie Lena Jackson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Ruth T. Jackson - wife 605 Idlewild Rd., Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta Data 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gardens 9-11-98 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Howard K. McComas III Funeral Home, P.A. mas 50 W. Broadway St., Bel Air, MD e, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory arrest, List only one cause on each line. 23a. Part1/ Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) CORONARY ARTERY DISEASE. /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaase or Injury that initiated evants Due to (or as e consequence of): thet initiated evants resulting in death) Last Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Wera autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1□ Yes 2 No 1 Tyes 22 No 25. Was casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident

P.O. Box 68760. Medical Certification: To

8

1 and 2 should be Health and Mental

Separtment of

Baltimore,

after deat Director: Hospital or within 24 hours a To the Funeral D completely filled

Registrar

To the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY. 5. NAIR M.D. 2112, BELAIR ROAD. FALLSTON. M.D. 21047.

6 Could not be determined

29b. Signature and title of certifier

3 Suicide

29a, Certifier

4 Homicida

Registrate Signeture

28a. Plece of Injury - At home, tarm, street, factory, office building, atc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated.

29c. License number

D 16444

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

SEPTEMBER 918 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Year **Physician** Eliza Lee Johnson 08 31 1998 3:39pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 N C 5. Social Security Number 8. Date of Birth (Month, Day, Year) Months Days Hours 1□M 2X F Yrs. 218-18-3939 79 05/03/1919 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director MD Harford Havre de Grace 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1405 Superior St 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married White 1 ☐ Yes 2 ZNo Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James A. DeBonis Pearl Hash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores L. Wilson- Daughter 816 S. Washington St., Havre de Grace, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 9/3/98 Bel Air, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD 21078 Hund 23a Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ð Alzheiner type 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 X ER/Outpatient 3 DOA Manner of 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician /Medical Examiner The state Attending Physicien: Division

Funeral

Director

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of Health and Mentel Hygiene.

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29b. Signature and title of certified

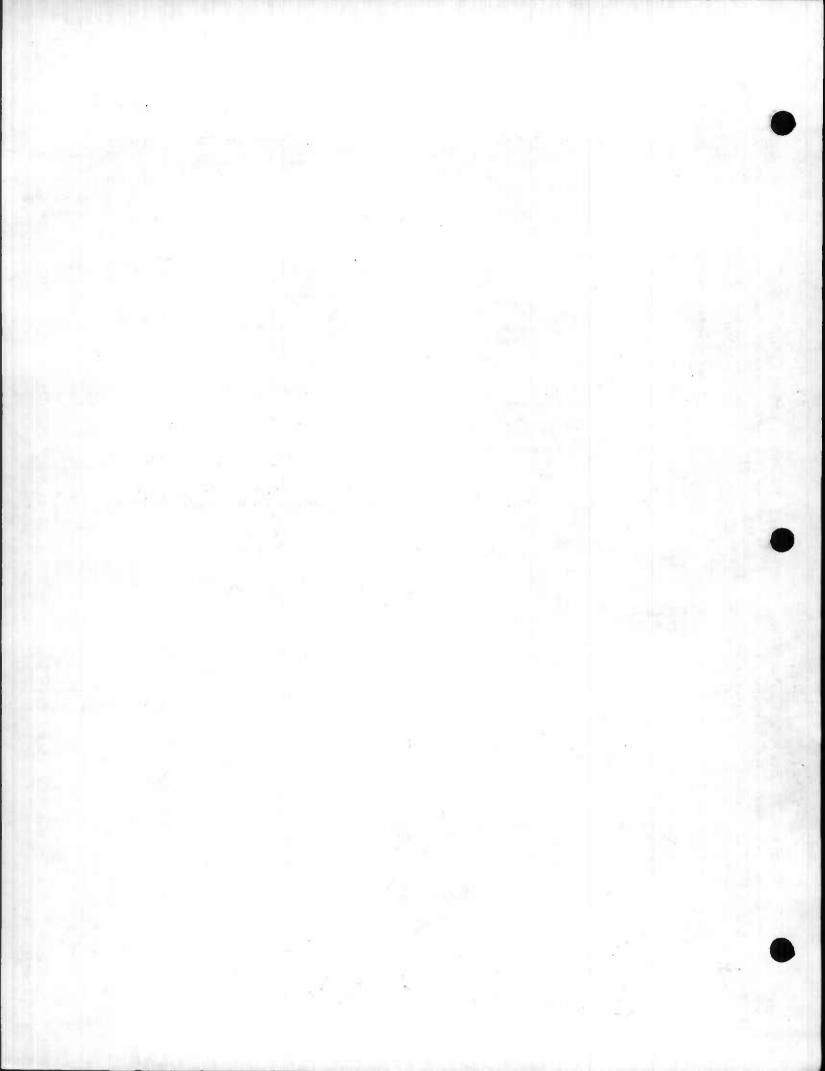
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Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) August 31, (Item 23a) (Type, Print)

Ablid

Registrar



DHMH 16 Rev 6/95

Registrar

SEP 0 9 1998

1 1 1 1 1

ROY CHARLES JOHNSON

Please Type or Print In Biack indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

3. Time of Death

Physiciar /Medica	NOT OTHERES COMMONIA ON	2. Date of D Month SEPTE	Deeth Day Year MBER 2, 1998	3. Time of Death 2253 PM
Examine	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea CAPITOL HEIGHTS	Prince Geo	rge's
Funeral Director	5. Social Security Number 579-04-8467 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M onths Days	Hours Min. 8. Date of E (Month, L) Rebruar		gton, D.C.
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5-0020 72 hours after death with the Manyland naturel; or items 23s or 28s-f show dies Examiner must be notified at	3 Widowed 4 Divorced Year or Dates:	lispanic Origin? (Specify Yes or Nan, Mexican, Puerto Rican, etc.) Specify:	14. Race - America Black, White, e Specify: Bla	tc.
Maryland 21215-0020 d 2 should be filed within 72 hours aft h and Mental Hygiene. 7 is marked other than "naturel", or traumatic event, tra Medical Exern traumatic event, tra Medical Exern traumatic event, traumatic event.	15. Decedent's Educetion (Specify only highest grede completed) Elementary/Secondary (0-12) 12th 15. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired) Carpet Cleane	during most of working d)	18b. Kind of Business/Inde	ustry
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Of V Physic rithis ce oral dire	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Ott	ner: 4 Nursing Home 5 Re	sidence 6 ther (Specify e how injury occurred	xene
Division of Vital Records, all or Attending Physicien: The law requires the ster death. 1 Director: After this certificate has been signed in by the funeral director, page 2 should be a considered by the funeral director.	1 □ Natural 2 □ Accident 3 □ Sulcide 4 □ Homicide 1 □ Natural 2 □ Accident 5 □ Pending Investigation 6 □ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Yes 2 No Pub	(Street end Number or Rure Fown, Stele) 5 605 Eag Height Man	Route Number,
spital of hours a morel D y filled		me, date and place, and due to the	ne ceuse(s) and manner as at	ated.

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) SEPTEMBER 3, 1998 111 Penn Street, Baltimore, Maryland 21201

Theodore King M.D. 31. Dete filed (Month, Day, Year) SEP 0 9 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32 Registrar's Signature

29c. License number

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Table 1 to No. 163

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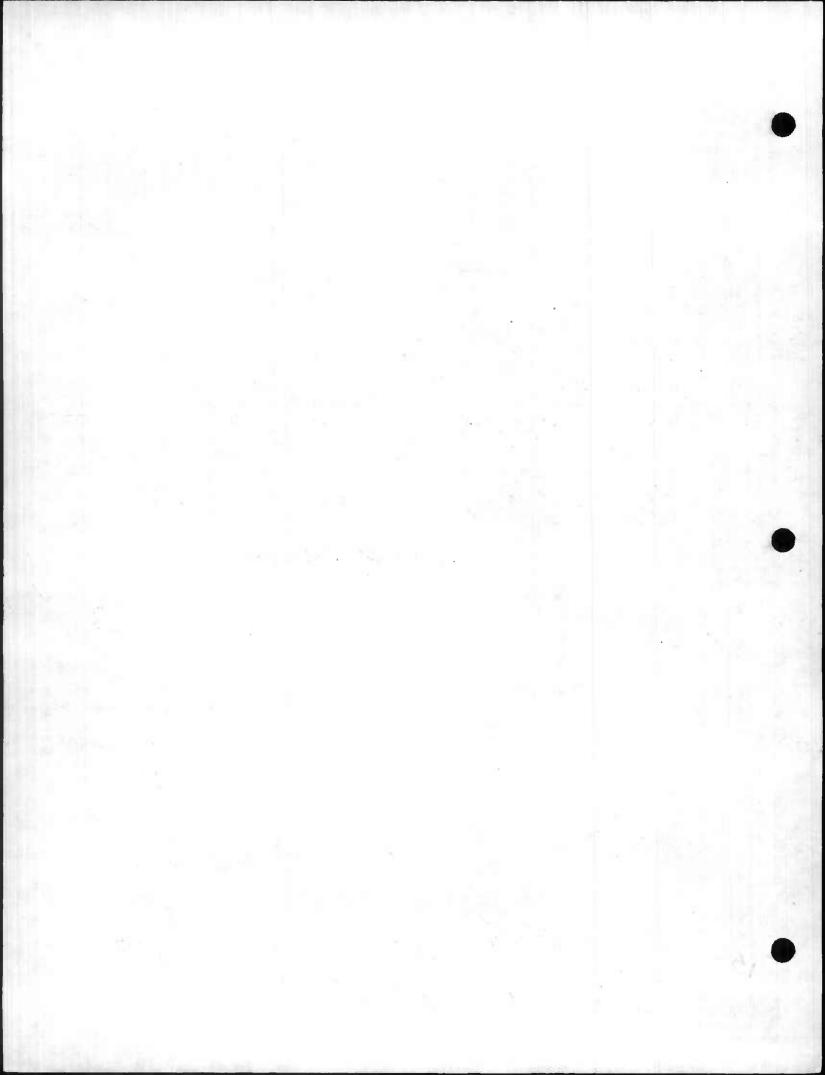
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 4, 1998 **Physician** Edward Kamita 2130 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford Hours Min. 8. Date of Birth (Month, Day, Year April 30, If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Connin)
(California Months Davs NOM 2 F Yrs 429-42-1484 78 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frams 23s or 28s-f show traumstic avent, the Medical Examiner must be not red ₹QYes 2 No Director MD Harford Aberdeen 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 240 Graceford Drive 21001 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2% No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Department of Haalth and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Item any Injury or other traumatic avent, the Mental DOGS. Bleck, White, etc. Never Married 2 Merried 1 Yes 20 No Specify: Specify: Japanese P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Social Security U.S. Government Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Tokuichi Kamita Ishi Hayashi 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Kimiko Kamita (sister-in-law) 240 Graceford Drive, Aberdeen, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) A. Ferris & Co., Inc. 9/5/98 West Chester, PA 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001-3399 23a. Pert1. Enter the disease, or complications that caused the deeth. shock, or heart failura. List only one cause on each line. Approximete Intervel Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examine be executed physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760 Physician/Medicai Due to (or es e consequence of) USB 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2 No 3 Probably Whitnown Records, þ 24b. Wera eutopsy findings available prior to completion of cause of death? should I 24a. Wes an autopsy performed? Completed has 1 Yes 2 No 1 Yes SE No cartificata 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Natural
2 Accident Division or Attanding 5 Pending investigation 1 TYes 2 □ No 24 hours after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medicai (Check only one) To the F 29b. Signeture end title of certified 29c. License number 29d. Date signed, (Month, Day, Year) 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Brint) State Registrar

DHMH 16 Rev 6/95

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KAMITA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death Reg. No.

			State of Walyla	Certificate of			J. No.	29362
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) MAN HEUNG	KANG		2. Dete of Daath Month	Day 4	3. Tima of Death
	Examine	er	4a Facility Nama (If not Institution, give street and number) SHADY GROVE ADVENTIST	HOSPITAL	4b. City, Town, or Lo	VILLE	4c. County MON	of Death TGOMERY
l	Funeral Director		213-96-4559 XM 20F 79	s. last birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,)	'ear's	9. Birthplace (State or Foreign
	Maryland H show	tor	Usual Residence of Decedent 10a. Stata 10b. County 10c. C	City, Town or Location	ours		J	10d. inside City Limits Yas 2□ No
	th with the 23a or 284	Funeral Director	10e. Street and Number Grinnell	10f. Zip Coda	855	109	p. Citizen of V	Vhat Country?
020	0 0	by Fune	11. Marital Status 1 □ Naver Married 2 □ Married 1 □ Naver Married 2 □ Married 1 □ Yes 1	U,S. 13. Was Decedent of I If Yes, specify Cub		ecify Yas or No- Rican, etc.)		e - Americen indian, k, White, etc.
21215-0020	within 72 hou ene. than "natura	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+)	16e. Decedent's Usual Occu (Giva kind of work done life OO NOT use retire	during most of works	16	Sb. Kind of Bu	isiness/Industry
-	should be filed within 72 hours nd Mental Hygiene. marked other than "natural", imatic event, the Medical Exe	To Be Co	17. Father's Name (First, Middle, Last)	2	18. Mother's Name	(Pist Middle, Ma	iden Sumam	HUNG
e, Maryland	and 2 salth ar 27 is or trau		19a Informant's Name/Relationship (Type, Print) PAU KANG (SON) 20a. Method of Disposition	19b. Mailing Address (Street	t and Number of Burn	R. FALI	YOUY	h Va 22406
Baltimore	Page nent o ant: If ury or		20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	cemelent crematory or drie nig	ess of Facility 1	8-98	O/	We a MD
B	Departr Importa any Inji		Dhelly Bell	4502	Stan Ho	TUNE S	f ler	nple Hill MI
	Physician /Medicai		23a. Part1. Enter the disease, or complications that caused the de shock, or heart tailure. List only one ceuse on each line. immediate Cause (Final disease or condition	ER OSMOLOW (ng, such as cardiac o	or respiratory arres		Approximate interval Between Onset and Death
e.	Examiner	lner	resulting in death)	(or as a consequence of): BEES MEU(his			YEARS
ox 68760,	ficate be physicial to the but	VMedical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	(or as a consequance of): (or as a consequance of):				
P.O. Box	that the death cer ed by the attendin detached for use	Completed by Physician/M	Pert II. Other algoriticant conditions contributing to death but not re Cenebro Upscubr Accident		iven In Pert i.	23b. Did tob		ntribute to the cause of death?
ecords,	aw requires that is been signed to 2 should be det	pleted by	SETURES			24a. Was an performe	autopsy ed?	24b. Were autopsy findings available prior to completion of cause of death?
al B	lclan: The law certificate has rector, page 2		Of Mr.			1 ☐ Yes	27 No	1 Yes 2 No
Division of Vital Records,	Phys ral di	tion: To Be	27. Manner of Death 1 Naturei 5 ☐ Pending 28a. Date of injury (Month, Day Year)	28b. Time of injury 28c. injury	her: 4 Nursing Ho	me 5 ☐ Residen 28d. Describe how		
Divisi	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Cuiside 6 Could not be	home, farm, street, factory, office		281. Location (Stre City or Town,	et and Numb State)	er or Rural Route Number,
	to the Hospital within 24 hours to the Funeral complately filled	edical	29e. Certifier (Check only one) 12 Certifying Physician: To the best of my kr one) 14 Certifying Physician: To the best of my kr one one of the basis of examiner and manner stated.					
•	To the to the comple	Σ	29b. Signature and title of certifiar A Security		sa number			d (Month, Day, Year) 2 6, 1998
	9		30. Name and address of person who completed cause of deeth (Its G. A. BELKEbi, 15200 S	em 23e) (Type, Print) VOUE	ROAD,	Rocalla	e ills	ry pro 20850

State Registrar Date filed (Month, Day, Year,

FP 0 9 1998

32. Begistrar's Signeture

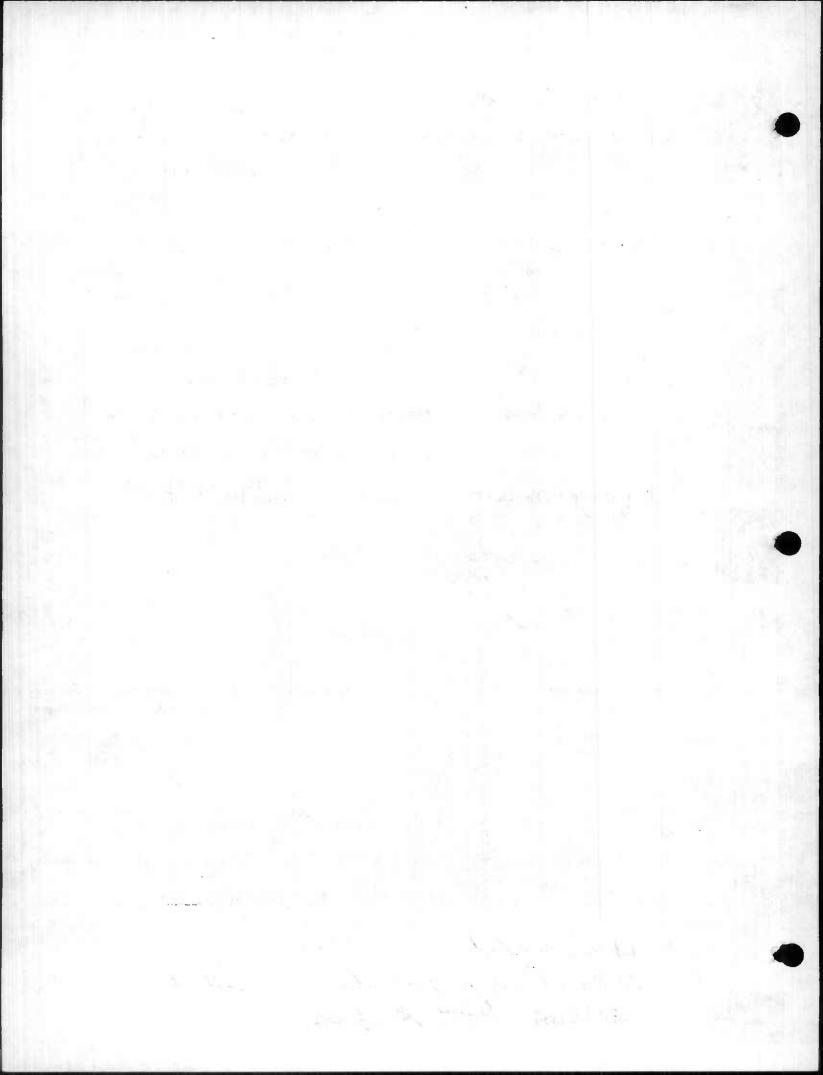
B. Sports

4 4 6 3 4 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

Physic		1. Decedent's Neme (First, Middle, Las Albert	F. Kelly	14.00	11 3	Text	2. Data of Dea Month	_	3. Time of Dec 98 1:58am
/Medi Exami		4a. Facility Nama (If not institution, give Westminster Nursi	e street and number)			4b. City, Town, or		4c. County	of Death
Funeral		5. Social Security Number 6. S	ex 7. Aga (in yrs.		Under 1 Yaar		8. Date of Birtl	Carro	
Director		Usual Rasidence of Decedent	MM 2□F 93	Yrs.	onths Days	Hours Min.	Feb 14	1905	Birthpiaca (Stata or Formatty) Mo
28a-f show notified at	tor	10a. State 10b. County Carroll		ty, Town or Locati ancheste					10d. Insida City L 1 ☐ Yas 2 [
23a or 28 unt be not	Funeral Director	10e. Straet and Number 3316 Wilhelm Lane			Of. Zip Coda 2110)2		0g. Citizen of V USA	What Country?
hygiene. ther than "natural", or frems 23a or 28a-f show ont, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Evar In U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	if Ya	Decedent of I s, specify Cub Yes 2 70	dispanic Origin? (S an, Maxican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Biad	e - American Indian, ck, White, etc. : white
than	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent (Give kind life. DO I	of work done NOT use retire	pation during most of wor d)		16b. Kind of Bu	usiness/Industry
and Mental Hygis is marked other aumatic event,	To Be C	17. Father's Nama (First, Middle, Last) Elisa Kelly					ne (First, Middle, eth Hans		ne)
12 t		19a. Informant's Name/Relationship (7 Nancy Kelly (dau	ghter)	19b. Malling A 1469 Fo	ddress (Street	and Number or Ru nt Ct.,]	ral Route Number Eldersbu	r, City or Town,	Stete, Zip Code) 21784
		20a. Method of Disposition 1 Data 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Disposition cemetery, cremator d Oakland	ry or other pla	ca) ery 9.			City or Town, Stata
Depertment of important: If it any injury or one once.		21. Signature of Funeral Service Licens Paigu Haught			me and Address	95 Sykes	aight Fu	neral He	ome & CHapel
g physician end as the buriel-transit	i Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	CHE	or as e consequen					3 m
attending physici for use as the bu	n/Medical	Cause (Disease or Injury that initiated events resulting in death) Last	d. ASCV	r as a consequence	ce of):				254
the atte	Physician/N	Part It. Other significant conditions co	ntributing to death but not res	uiting in the under	lying cause giv	ven In Part I.	23b. Did to	bacco use cor	ntribute to the cause of de
igned by the a be deteched f	by Ph						1 🗆 Y	2 10	3 Probably 4 Unk
s been s 2 should	Completed						24a. Was a perform		24b. Were autopsy findin available prior to completion of cause of death?
pa	Be Cor	25. Was case referred to medical				De Diago of Dag	1 🗆 Y	1	1 ☐ Yes 2 ☐ No
this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	□ DOA Oth	44	th (Check only on ome 5 - Reside		er (Specify)
After fune	ation:	27. Megner of Death 1. Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Tima of tnjury	28c. Injur Wor 1	yat k? Yes 2 □ No	28d. Describe ho	w Injury occurr	ed
25.5	Certification:	3 ☐ Suicida 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	oma, farm, streat, f	actory, office		28f. Location (St City or Town	reet and Number, State)	er or Rural Route Number,
al Director:		29a. Certifier 1 Certifying Phy	alcian: To the best of my knowner: On the basis of examinat	wledge, death occition and/or Investig	urred at the tir gation, In my o	ne, dete and plece, pinion, death occur	and due to the cared at the time, d	use(s) and me ate and piace, a	nner as stated. and due to tha cause(s)
Funeral Director: letely filled in by the		(Check only 2 Medical Exami	and manner stated.						
within 24 hours eller deem To the Funeral Director: A completely filled in by the f	Medical	Check only 21 Medical Exami	and manner stated.		29c. Licens	a number	2	d. Data signed	(Month, Day, Year)
To the Funeral Director: completely filled in by the	Medicai	29b. Signature and titla of cartifian	and manner stated. Modulation of the state		Da	a number	J MIDD	09/03	(Month, Day, Year)

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month Year **Physician** SEPTEMER 7,1998 KRAFT SARAH 1610 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Salisbury If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10M 20F Days 91 Pennsylvania Director 218-48-7201 10/26/1906 Usuel Rasidance of Dacedant 10d. Inside City Limits 10a Stata 10b. County 10c. City, Town or Location 1 Yas 2 No Director 288-1 Maryland Somerset Princess Anne 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ŏ 21853 11974 Edgehill Terrace USA Berrs 23a 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Yas 2 No 1 Never Merried 2 Married natural, or 1 Yas 2 No Specify: Baltimore, Maryland 21215-0020 à 3 Widowed 4 □ Divorced White Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 8 Housewife Own Home Pages 1 and 2 should be filed name of Health and Mental Hygi-int: If Ilem 27 is marked other 17. Father's Nama (First, Middla, Last) 18 Mothar's Nama (First Middle Maiden Surnama) Be Maurice Robert Harbaugh Ida Jane Wilt 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) important: If Item 27 any Injury or other tr 13326 Pine Beach Road, Princess Anne, Md. 21853 Ralph Kraft, Jr./Son 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition

12 Burial 2 Cramation 3 Ramoval from Stata Data 20c. Location - City or Town, State Springhill Memory Gardens 9/11/98 4 Donation 5 Othar (Specify) Hebron, Maryland 22. Name end Address of Facility Signature of Funeral Service Lice Hinman Funeral Home 23a. Parl1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Princess Anne, Md. 21853 Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final - Heart Pase one disaasa or condition rasulting in daath) Examine Examine vin devon Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaase or injury thet initiated evants rasulting in death) Last Dua to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Dtd tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No kho cute Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 2 No 1 ☐ Yas 2 ☐ No of Vital 25. Was case rafarred to medical Be 26. Placa of Death (Check only ona) To 1□ Yas 28 No Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27 Manner of Death 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? After Division or Attending 1 Anatural 5 Panding invastigation n 24 hours after death.

The Funeral Director: After the further t 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifian (Check only one) To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name end addrass of person who complated causa of death (Item 23a) (Type, Print) Roa Evang 32. Registrar's Signatura

DHMH 16 Rev 6/95

State Registrar

State of Maryland / Department of Health and Mental Hygiene

			1. Decedent's Neme (First, Middla,	Last)							2. Dete of D				3. Time of Death
Phys	iician dical		Judith		Col	well			Lin	inger	Sept.	3, 19	998	Yeer	7:43 PM
	niner		4e. Fecility Neme (If not institution,	give street en	d number)					4b. City, Town, o			County	of Deeth	7.433 EF.
			8502 Wellington	n Valle	ev Way	7				Lutherv	ille	E	Balt:	imore	
Funera	al	1		6. Sex	7. Ag		ast birthde	y) If Under Months				irth Day, Year)			ace (State or Foreign
Directo	or		147-32-9759 Usual Residence of Decedent	1□ M 202	Ç- E	57	Yrs.	WIGHT	Doys	110013	May 19	, 194	11		Jersey
aryland show	_		10a. Stete 10b. County				, Town or							10	d. Inside City Limits
ha M	oct o	3	Maryland Balti	more		Lu	ther								
Mith Dec	늅	5		. **-11-	T.7			10f. Zip		100		10g. Citi		Vhet Count	ry?
aath 23	era	5	8502 Wellington		Decedent E	•	C 115	3 Was Doods	210		Cassify Van as h	10	USZ	A. e - America	n Indian
filed within 72 hours after death with the Maryland Hyglena. ther than "natural", or items 23s or 28s-f show ent, the Medical Exeminer must be notified at	Completed by Funeral Director		11. Marital Status 1 □ Never Merried 2⊠ Marrie 3 □ Widowed 4 □ Divorced	Arme	ed Forces? Yes 2 XN s, Give or Dates:		5.	It Yes, speci		Hispenic Origin? an, Mexican, Pue Specify:	no Rican, etc.)	10-		k, White, e	tc.
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f within 72 hallens. Jens. r than "natur	agu	-	Elementary/Secondery (0-12)		ge (1-4or 5	+)				during most of w d)	OIKIIG				
filed within Hyglena. Wher than	ပ်	5		4	1		F	Homemak	cer	T			n Hor		
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2 should be and Mental a marked o	ု	2	Joseph Leste	er Co	olwell	L				Paula	Lı	nnae	Ma	annin	en
d 2 should th and Mer 7 la marke traumatic		1	19a. Intormant's Name/Reletionshi	p (Type, Print))		19b. Me	iling Address	(Street	and Number or	Ru <i>ral Rou</i> te Num	ber, City o	r Town,	Stata, Zip (Code)
		-	John L. Lininge	r/ Hush	pand	1	850	02 Well	Ling	ton Val					MD 21093
		12	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removai f	from State	20b. Pi	aca ot Dis ematary, ci	position (Nam ramatory or ot	na of ther pla	ce)	Date			City or Tow	
Pag mant: uny			4 □ Donetion 5 □ Other (Spe		om otato	Sa	ter's	s Churc	ch C	Cemetery	9-9-98	Luth	nerv	ille,	Maryland
pemit. Pages 1 ar Department of Hea Important: If Itam any Injury or other	DUCE		21. Signeture of Funeral Servica L	1. Em	10)	5			rd F	. McCom					
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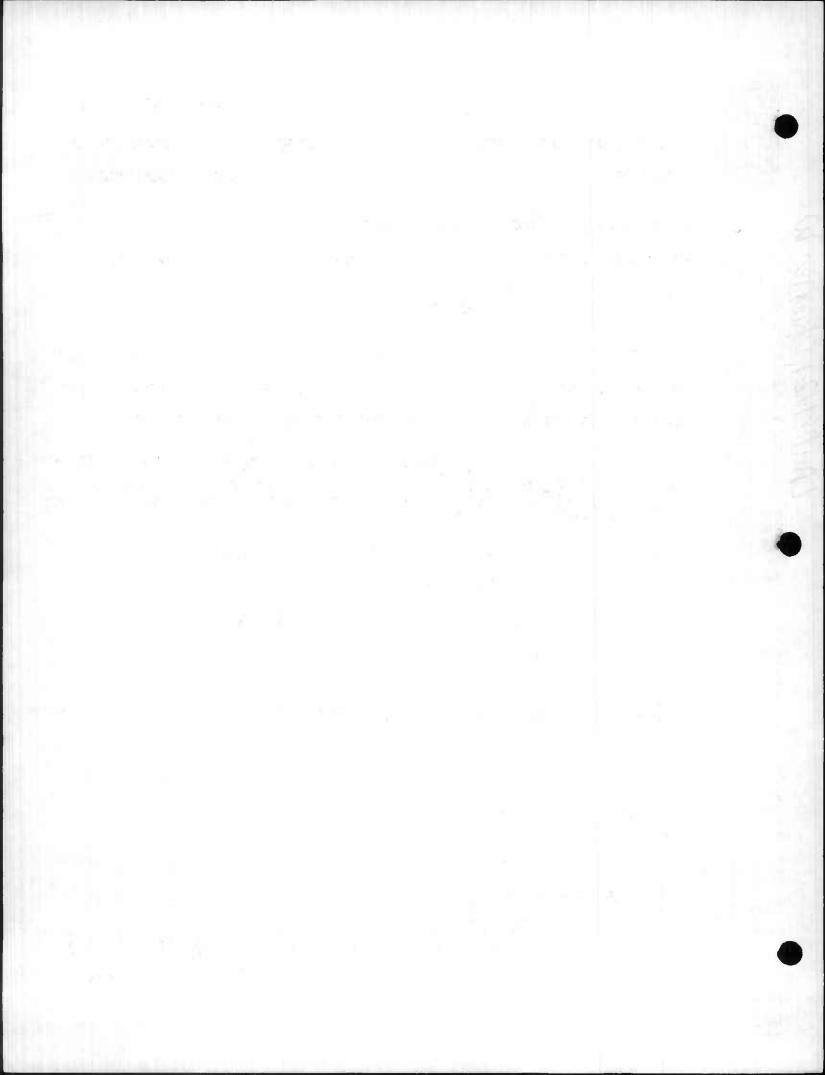
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacedent's Neme (First, Middle, Lest) 2. Dete of Death **Physician** September 5, 1998 9:55AM CHARLES WESLEY LAURENZI /Medical 4b. City, Town, or Location of Deeth 4e. Facility Name (If not institution, give street and number) 4c. County of Daeth **Examiner** DOCTOR'S COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Yaar | If Undar 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Sacurity Number 6 Sex 7. Aga (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Yeer) **Funeral** 1 ☑ M 2 □ F Yrs. Director 578-22-7600 MARCH 5, 1925 MARYLAND Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 35No Funeral Director 288-1 MARYLAND PRINCE GEORGE'S SEAT PLEASANT 10g. Citizen of Whet Country? Herrie 23s 312 ROLLINS AVENUE 20743 U. S. A. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Rece - American Indian, Bieck, Whita, atc. 1 Yas 2 No If Yes, Give Yaar or Dates: 143 -146 1 Never Marriad 2 Married 1 ☐ Yes 2 No Specify: WHITE by 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 IRON WORKER IRON WORKERS UNION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ANTONIO LAURENZI ELIZABETH (UNAVAILABLE) 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN BOERTLEIN/FRIEND 6336 JOHNS LANE DUNKIRK, MARYLAND 20754 Nem 27 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Locetion - City or Town, Stete SEPT. Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MD VETERANS CEMETERY 10.1998 CHELTENHAM, MARYLAND 21. Signature of Funerel Ser LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MARYLAND BLVD. OWINGS, MD ock, or heert lature eath. Do not enter the mode of dying, such as cardiac or respiretory errest, **Physician** RESPIRATORY /Medical Immediete Ceuse (Finel diseese or condition resulting In death) FAILURE **Examiner** Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Box 68760, Physician/Medical Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown Records. þ 24e. Wes en autopsy performed? 24b. Were eutopsy findings aveilable prior to complation of causa of deeth? 2 200 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 → hpatiant 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending Investigation Watural s efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 6 4 Homicide a Funeral Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete and place, end due to the ceuse(s) end manner stated. edical 29a, Certifier To the Hosp within 24 hos To the Fune completely fi 29b. Signatura and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Day Year LAURA A. LOBERG 8, SEPT. 1998 1:15 AM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY CO. 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) **Funeral** 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 1 M 2 KF Days Hours 563-46-6790 92 Yrs. Director JAN.29,1906 MINNESOTA Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MONTGOMERY CO. MD. ROCKVILLE Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 death with 14004 PARKLAND DRIVE 20853 238 USA Funeral items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 11. Maritel Stetus 12. Was Decedent Ever In U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 Married 21215-0020 6 1 Yes 2 No Specify: WHITE Completed by 3. Widowed 4 □ Divorced Specify: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4or 5+) 12 CAFETERIA WORKER FOOD other 1 Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Ith end Mental 27 is marked of traumatic ever Pages 1 and 2 should be nent of Health end Mental PETER J. WEENS LENA DAHLBORO 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health e Important: if item 27 is any injury or other tra LAURA D. DOSCHER-DAUGHTER 14004- PARKLAND DR., ROCKVILLE, MD. 20853 Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Walter and State 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRINGDALE CEM. 9/13/98 SIOUX FALLS, S.D. 21. Signature of Funeral Se 22. Name and Address of Facility HYSONG CO., INC. caused the deeth. Do not effer the mode of dying, such as cardiac or respiratory arrest. 23a. Part1. Enter the disees shock, or heart failure. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final diseese or condition resulting in death) **Examiner** Examiner leroeis NO SC The law requires that the death certificate be executed buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequença of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably A Unknown by Completed Were autopsy findings evaileble prior to 24a. Was an eutopsy performed? completion of cause of death? Sec certificate 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 28. Piaca of Death (Check only one) 1□ Yes 2☑ No Other: Varing Home 5 Residence 8 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation deeth. 1 Yes 2 No 2 Accident Director: / 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) after 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) MP 2852 01 ev 32 Registrar's Signature 31. Date filed (Month, Dey, Yeer) State **SEP 09 1998**

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Registrar

SEP 0 8 NOS

North I

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

ELKMILLS RD.

Joshua Matthew McQuerrey

4a Fecility Neme (If not institution, give street end number)

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate	of	Death

4c. County of Deeth

Cecil

Month Dey Year SEPTEMBER 12, 1998

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Yes 2 No

Approximate Interval Between Onset and Deeth

24b. Were autopsy findings eveileble prior to

completion of cause of death?

1 Yes 2□ No

Collision

29d. Dete signed (Month, Dey, Year)

SEPTEMBER 13, 1998

AT

Maryland

White

12:17 PM.

2. Dete of Deeth

4b. City, Town, or Location of Death

	Funeral Director
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Dopartment of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event, the Modesi Examiner must be notified at DDCs.

Physician

/Medical

Examiner

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signed by the a

is certificate has director, page 2:

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funeral

thet the deeth certificate be executed

Box 68760.

P.O.

Division of Vital Records.

Physician:

Attending

death.

or A effer

To the Hospital or A within 24 hours effer To the Funeral Direcompletely filled in b

CHERRY HILL
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) If Under 1 Yeer 5. Sociel Security Number 6 Sex 7. Age (In yrs. lest birthday) 12 M 2 ☐ F Months Deys Yrs. 213-98-5322 16 October 20, 1981 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Director Maryland Cecil Elk Mills 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 16 Frame Row Lane 21920 United States Funeral 14. Rece - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Student 11 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Jeffrey W. McQuerrey Ruth A. Roark 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) P.O. Box 80, Elk Mills, Maryland 21920 Jeffrey W. McQuerrey/father 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriai 2 ☐ Cremetion 3 ☐ Removal from State September 16, 4 ☐ Donetion 5 ☐ Other (Specify) Elkton Cemetery Elkton, Maryland 1998 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 21. Signature of Funerel Service Licensee 103 West Stockton Street, Elkton, Maryland 21921 . Hicks her 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ eted 24e. Wes en eutopsy performed? Compl 1 Peres 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Deeth (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred OriveSCENE 28a. Dete of Injury (Month, Dey Year) 28b. Time of 27. Manner of Death 28c. Injury et Work? Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☑No 1200 PM 9-12-98 Aulo - Aulo 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number City or Town, Stete) 4 - Homicide Roaduar EUKMIUS 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner es stated.

2X Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier edical

4

31. Dete filed (Month, Day, Year)

Javill

29b. Signeture and title of certifier

(Check only one)

32. Registrer's Signeture

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

Puller

SEP 1 5 1998

Sports

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95

State

Registrar

State of Maryland / Department of Health and Mental Hygiene R 200 R CO

		Decedent's Nama (First, Mid	idio I ast)			Cei	rtificat	e or i	Deam	2. Date of Dea	leg. No.		3. Time of Death
Physician	n									Month	Dey	Yaar	
/Medical	al -	Helen Frances									per 10,		0045 7
Examiner	r	4e. Facility Nama (If not Institut	ion, give s	treet and numb	er)			4	b. City, Town, or	Location of Death	4c. County	of Death	
		Sunrise Care F	acil	ity					Elkton		Ceci		
uneral		5. Sociel Security Number	6. Sex		Age (In yrs.	last birthdey)	If Under Months	1 Yaer Days	If Undar 24 Hrs Hours Mir		Year)	9. Birthplac	e (Stete or Foreig
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Mon III		10a. Stata 10b. Coun	ity		10c. Ci	ty, Town or Lo	cation					10d	fnside City Limit
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or 2	Director	10e. Street and Number					10f. Zip	Coda			10g. Citizen of	What Country	7
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ef, or items 23a or 28a-f show Examiner must be notified at the Funeral Director	Jy r.	1 Nevar Married 2 Mi 3 X Widowed 4 Divorce		1 ☐ Yas 2j If Yes, Give Yaar or Data	₩ No		1□ Yas			, , , , , , , , ,	Specif		
S S S	8	15. Deced				16a. Dece	dant's Usua	I Occup	etion		16b. Kind of B		
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important: if Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examples. To Be Completed by F	0	James Cain							Helen	Cavanaug	n		
E E		19a. Informant's Name/Reletio	nship (Typ	oe, Print)		19b. Meilir	ng Addrass	(Street	and Number or F	Rural Route Numbe	r, City or Town,	State, Zip Co	ode)
27 le		Joseph J. McKe	own/	son		4 Pho	enix	Driv	ve, Bear	, Delawa:	re 1970	1	
E offi		20a. Mathod of Disposition				Place of Dispo	sition (Nan	ne of ther plac	el Cant	ember 10	20c. Location	City or Town	, State
any or of		1 ☐ Burial 2 ☑ Cramation 4 ☐ Donation 5 ☐ Other		emovel from Sta	ta				ompany	,		t Ches	
iniu	-	21. Signature of Funarai Sarvio		0	1200	22	2. Name en	d Addras	ss of Facility			nsylva	nıa
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hed hed	35	Part II. Other significant condi	tions cont	ributing to death	but not ras	ulting in the u	nderlying c	ausa giv	an in Part I.	23b. Dfd t	obacco use co	ntribute to th	ne cause of deal
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director, page 2 s director, page 2 s To Be Comple		25. Was casa rafarred to medic examinar?	cal						26. Place of De	ath (Check only o	ne)		
this ce al dire		1 Yas 2 No	H	ospital:	atient 2	ER/Outpatler	nt 3 DO	A Oth	er: 4 Nursing	Homa 5 ☐ Rasid	anca 8 □Oth	ar (Specify)	
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al Director: After tied in by the funeral	2	3 ☐ Suicida 6 ☐ Coui 4 ☐ Homicida deta	d not be	28a. Piace of	Injury - At h	oma, farm, str	eet, factory	, office		28f. Location (S City or Tow		per or Rural R	loute Number,
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the Funeral Di npietely filled in Aedical Cer	-						29c	Licens	a number	-	29d. Data signs	d (Month, Da	v. Year)
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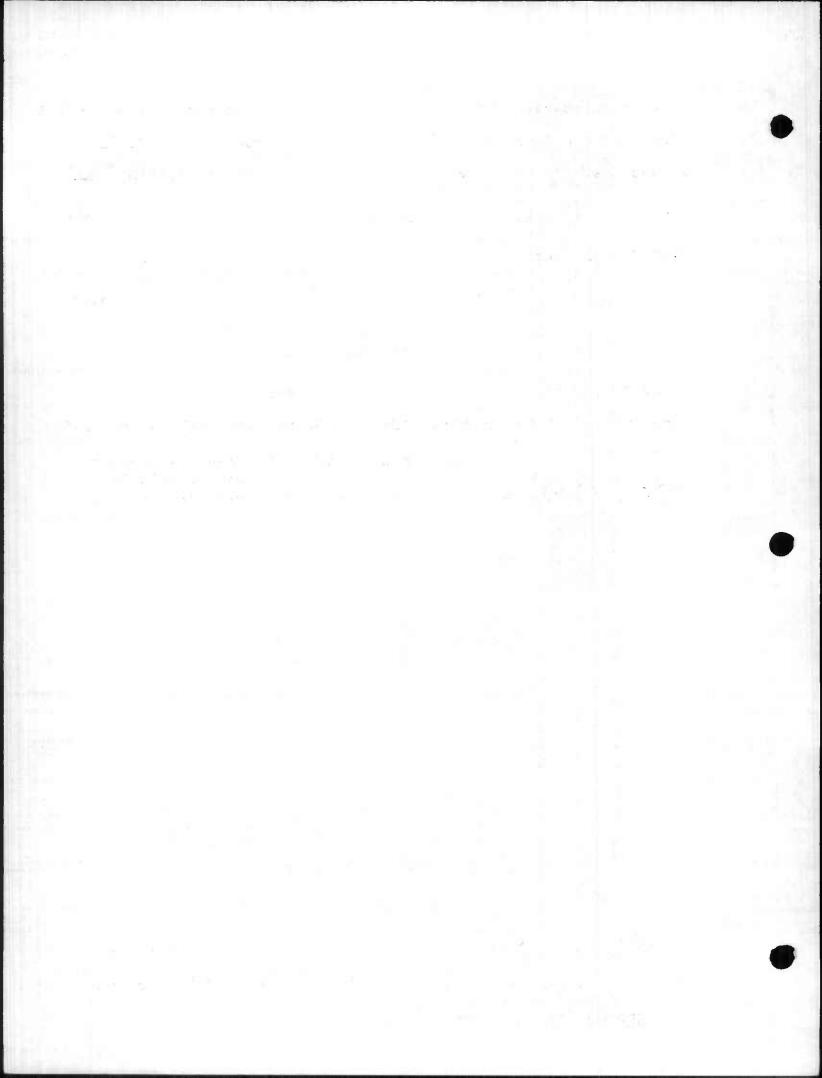
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month Year **Physician** Dorothy Elizabeth Morris 7,1998 September 4:55 PM /Medical 4a. Facility Nama (If not institution, give street and number) 4c. County of Death 4b. Cify, Town, or Location of Death Examiner Sunrise Care Facility Elkton Ceci1 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth Months Days Hours Min, (Month, Day, Year) Birthpiaca (Stata or Foreign Country) **Funeral** Months Days 1□M Q□F 216-38-2697 Yrs. 83 Director October 6,1915 Md Usual Residence of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examinar must be notified at Md. Ceci 1 Y□ Yas 2□ No Director Elkton 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? death with 150 E. Main Street 21921 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Biack, Whita, atc. 11. Marital Status permit. Pagas 1 and 2 should be filed within 72 hours after c Depurtment of Haelih and Mental Hygiena. Important: If Item 27 is marked other than "natural" 1 □ Navar Married 2 □ Married 1 ☐ Yas ② ☐ No Specify: White p Specify: 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Kitchen worker 4 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 2 Jack Robinson Inice Wythe 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Bonnie L. Wallace, Daughter 121 Plum Point Road, Elkton, Md. 21921 20b. Piace of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Galena Cemetery 9/12/98 Galena, Md. 22. Nama and Addrass of Facility 259 E. Main St., Gee Funeral Home Elkton, Md. 21921 23a. Partt. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, about, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medicai Immediata Causa (Finai & CAUTEYIA wo. disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner wo. CANCER OF THE BRAN The law requires that the deeth certificate be executed burial-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaase or injury that initiated avants rasulting in death) Last and Dua to (or as a consequence of): physician s the burial Box 68760. mo CAN UEN OF THE MMPH NOBES Physician/Medical Dua to (or as a consequanca of): 60 ancen 1 YEAR COLDN THE OF 50 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contributs to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown signed be det Records, by 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed peen has page 1 Yas 2 No 1 Yes 2 No cartificata Division of Vital after deeth.

Director: After this cartifica 25. Was casa rafarred to medical Be 26. Placa of Daath (Chack only ona) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Homa 5 Rasidanca 6 Other (Specify) 2 1 Yas 2 No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 3 Suicida 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 2 4 - Homicida 24 hours a Funeral D 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifiar Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signatura and titia of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 007463 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) Mary land A. Najera, M.D., F.A.A.F.P III West High Street Suik 214 EIRfon, (MD) Rolando 31. Data filad (Month, Day, Year) 32. Registrar's Signatura State

DHMH 16 Ray 6/95

Registrar

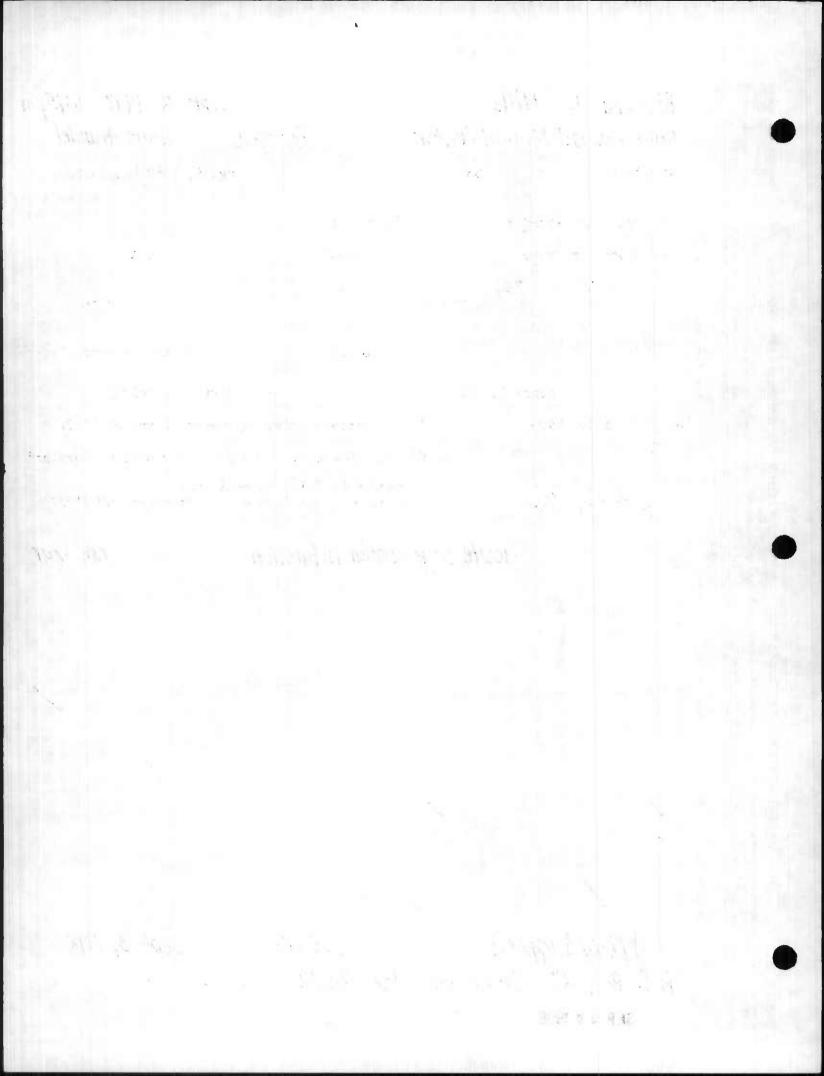
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

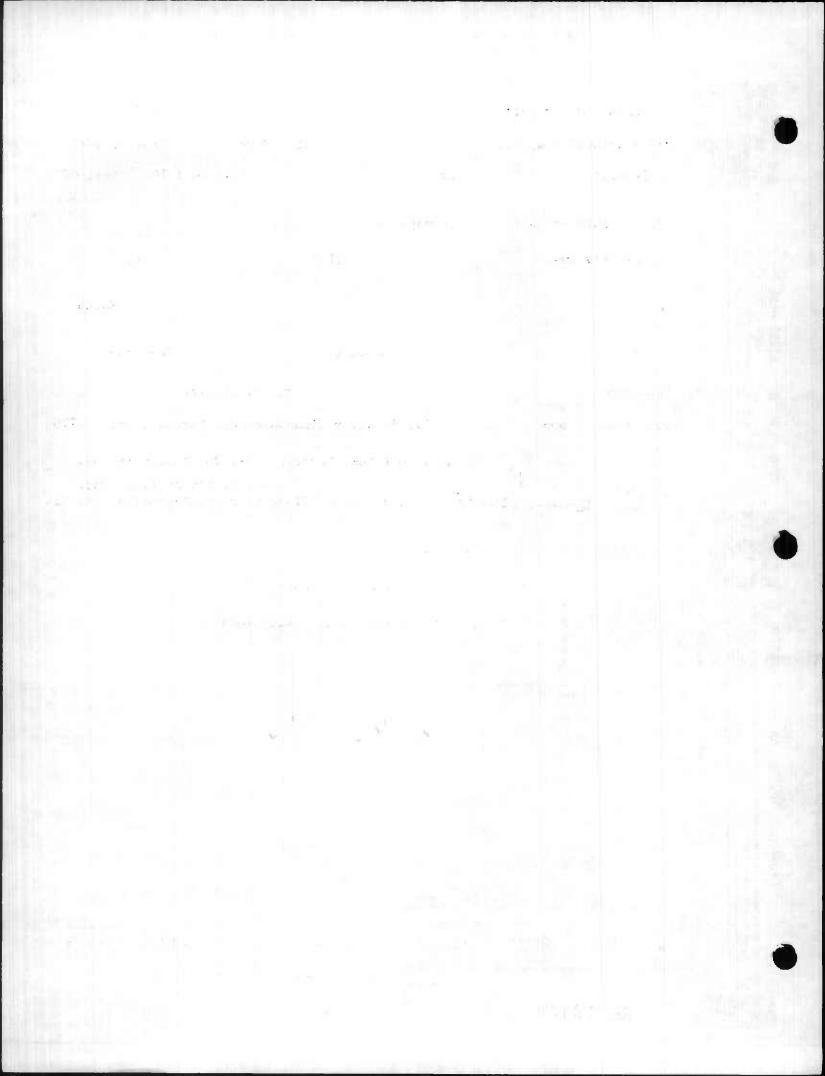
		Decedent's Name (First, Middle, La	st)		Cei	tifica	te of	Death	2. Data of De	Reg. No.		3. Tima	of Death
Physiciar /Medica	n si	Richard L	MILIS						Sept	- 2	998	6:	15pm
Examine	r	4a Eacility Name (If not institution, give Anne Annoc!	e straat and number Medical	Cent	ter			Annapo	dis	Ann			:/
Funeral Director		5. Social Security Number 6. S 579-52-7362	D	ge (In yrs. 6	lest birthday) Yrs.		Days	H Under 24 Ars. Hours Min.	8. Dete of Bir (Month, Da Aug. 4	y, Yeer) , 1942	9. Birthi Cou Washi	olace (Stete otry) Lngtoi	n, DC
worke		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1		City Limits
the Maryler 28a-f ehow notified at	9010	Maryland Anne Ar	undel		Ed	gewa				40. 000	***		BS ZLANO
death with the Maryland rms 23s or 28s-f show I namt be notified at	a 0	10e. Street and Number 1280 Crossover Dr	ive				1037			10g. Citizen of US		ntry?	
offer in	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forcas 1. □ Yes 2 ☐ If Yes, Giva Yaar or Dates	?] No		Was Dece f Yas, spo 1 ☐ Yes	TT	ispanic Origin? (Sp an, Mexican, Puarto Specify:	pecify Yas or No Ricen, etc.)	- 14. Rad Bla Specil	ck, Whita,		
in 72 ho	Completed by	15. Decedent's E. (Specify only highest gra	ducetion		16e. Deced (Give lifa.	dent's Usu kind of w DO NOT		ation during most of work f)		16b. Kind of B	usiness/In	dustry	C
Hygie of the the	3	12th 17. Father's Name (First, Middle, Last,				SLOC	ker.	18. Mother's Nam		Safeway Meiden Sumei		ery a	store
Nore, Maryland 212 ges 1 and 2 should be filed with it of Health and Mental Hygiene. If flam 27 is marked other that or other traumatic event, treat	0 00	Н	enry L. M	ills	100 140		. (04	Edit	h Berth	a_Weige	ldt	Codel	
2 % a . a		19a. Informant's Name/Relationship (Judy M. Mills/ Wi						end Number or Ru					7
re, N s 1 end t f Health fam 27 other tr	-	20e. Method of Disposition		20b. F	Place of Dispo	sition (Ne	me of	r Drive E	Date	20c. Location			
Pa Pa		1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			Veter				9-98	Crownsv	ille,	Mary	yland
Baltimore, N permit. Pages 1 end Department of Health Important: if itam 27 any Injury or other to		21. Signature of Fuseral Service Light	10/					ss of Facility Kalas Fun ons Islan			∽ MT	210	27
		23a. Pa. Enter tha disease, or com shock, or heart failure. List only	plications that ceus	ed the deal							1, 111	Approxin	nate
Physician /Medical Examiner	ler	Immediate Cause (Final disease or condition rasulting in death)	a acui	Due to (YOCA	rdia.	1 in	farction				Onset an	nour
D&/DU, tificate be executed applysician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	b	Dua to (d	or as a consec	quence of	:				1		
		Ceuse (Disease or Injury thet initiated events resulting In death) Last	d	Due to (d	or as a conseq	uence of)	:						
death cert death cert e attendin ed for use	clar	Part II. Other algnificant conditions of	ontributing to death	but not res	ulting in the u	nderlying	ceuse ah	ren in Part I.	23b. Did	tobacco uae co	ontributa 1	o the caus	e of defith
	by Physician/M									Yee 2□ No			Unknow
ev requir	Completed								24a. Was	an autopsy ormed?	av co	ere eutops vailable pricomplation of death?	or to of ceuse
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Of Vital Ke Physician: The le this certificate he ral director, page	0 0	25. Was case referred to medicel axapriner? 1 ☑ Yes 2 ☐ No	Hospital:	tient 20	ER/Outpetier	nt 3 🗆 🖸	OA Oth	26. Place of Dee	ome 5 Resi		her (Speci	ifv)	
0 5 5 6	KIOU:	27. Menner of Deeth 1 Metural 5 Pending 2 Accident Investigatio	28e. Dete of In (Month, E		28b. Time of Injury		28c. Inju			how injury occu		,,	
DIVISION OF To the Hospital or Attending Ph. Within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	Certifica	3 Sulcida 4 Homicide 6 Could not be determined	e 28e. Place of I	njury - At h etc. <i>(Speci</i>		reet, facto	ry, office		28f. Location (City or To	Street and Num wn, State)	ber or Ru	ral Route N	lum <i>ber</i> ,
To the Hospital or within 24 hours effer to the Funeral Dir completely filled in	BOICE		yalcfan: To the bes niner: On the basis and manner:	of examina									e(s)
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Day Month **Physician** 4-35 PM SEPTEMBER 4 1998 Pauline H. Mevett Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Glen Burnie North Arundel Hospital Anne Arundel If Under 1 Year Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 M 2 K F Yrs 80 June 24,1918 Director 216-18-4214 Maryland Usuel Residence of Decedent with the Marylend 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street end Number 10f, Zip Code 627 Ridgely Ave. 21401 Funeral USA deeth 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, etc. 11. Marital Stetus filed within 72 hours efter 1 Yes 2 No If Yes, Give Year or Datas: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 Yes 2√2 No Specify: à 3 XWidowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home treumetic event, permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Nem 27 Is marked oth any liqury or other treumstic event Rods. 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be "Unknown" Anna E. Eichler 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) Jerome Smith / son 211 S. River Clubhouse Rd. Harwood, Md. 20776 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 XBuriel 2 Cremetion 3 Removel from Stete Hillcrest Mem. Cemetery 9-9-98 4 ☐ Donetion 5 ☐ Other (Specify) Annapolis, Md. 22. Name and Address of Facility John M. Taylor F.H., Inc. 21. Signeture of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, the Md. 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disaese or condition resulting in death) SEPSIS Examiner Due to (or es e consequence of): Examiner BLEED ASTROINTESTINAL ettending physicien end for use es the bunel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest ACUTE MYELOCYTIC LEUKEMIA Box 68760. Physician/Medical ed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Onknown by Division of Vital Records. 24b. Were autopsy findings eveileble prior to completion of causa of deeth? 24e. Wes en eutopsy performed? Completed certificate has 1□ Yes 2□No 1 Yas 2 No 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28e. Dete of Injury (Month, Day Year) uneral 28b. Time of 27 Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: I or Attending P efter death. I Director: After 1 Natural 5 Pending invastigation 1 Tyes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner steted. (Check only one) To the F within 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40 D 46962 SEPTEMBER 5, 1998 Tal Glen Burnie L. MD 21061. 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) MISHIRAZI, M.D. NORTH ARUNDEL HOSPITAL. 31. Date filed (Month, Day, Year) SEP 0 8 1998 32. Segistrer's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month FREDERICK PHILIP MANNS Sept. 5, 1998 10:15 AM /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 206 Briarcliff Lane Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9/23/1940 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (Stata or Foreign Country) **Funeral** 1**₩**M 2□F Yrs 213-38-7326 57 Director Maryland Usuei Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2 ☑ No Md. Harford Bel Air other traumatic event, the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? ŏ items 23a 206 Briarcliff Lane 21014 U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 14. Rece - Amaricen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, apecify Cuben, Maxicen, Puerto Ricen, etc.) Peges 1 and 2 should be filed within 72 hours effer or nent of Heelth and Mentel Hygiene. Int: If Item 27 is marked other then "neturel", or Nei 1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Giva Year or Detas: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Caucasian by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast greda completed) 16b. Kind of Bualness/Industry College (1-4or 5+) Elementary/Secondery (0-12) Store Owner Office Supplies 17. Father'a Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Manns Philip Thweatt Mary Alice McClain 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 s Department of Heelth an Important: if item 27 is i eny injury or other trausonce. Cheryl A. Manns (Wife) same as #10 20b. Placa of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremetion 3 ☐ Ramoval from Stete 4 ☐ Donation 5 ☐ Other (Specify) 1998 Carroll Cremation Hampstead, Maryland 21. Signature of Funaral Service-Licensee 22. Nama and Addrass of Facility
E. G. Kurtz & Son, P.A. Jarrettsville, Maryland 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each Approximate interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) COLON CANEER - METASTATIC Examiner Due to (or es e consequence of): Examiner CIABETES MOLLITIS physician and the buriel-transit that the deeth certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of) Box 68760, Physician/Medical Due to (or es e consequance of): 80 signed by the a Part il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ should 24b. Were autopsy findings available prior to completion of causa of deeth? Completed 24a. Wes an autopsy performed? certificate hes b director, page 2 s 1 ☐ Yas 2 👿 No 1 ☐ Yes 2 ☐ No or Attanding Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Tima of 28c. Injury et Work? After 1 Natural 2 Accident 5 Pending deeth. 1 Yes 2 No invastigetion hours after deeth 6 Could not be determined 3 Suicide 28a. Pleca of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide 24 hours Hospital to certifying Physician: To the best of my knowledge, deeth occurred et the time, data and piece, end dua to the causa(s) end menner as stated.

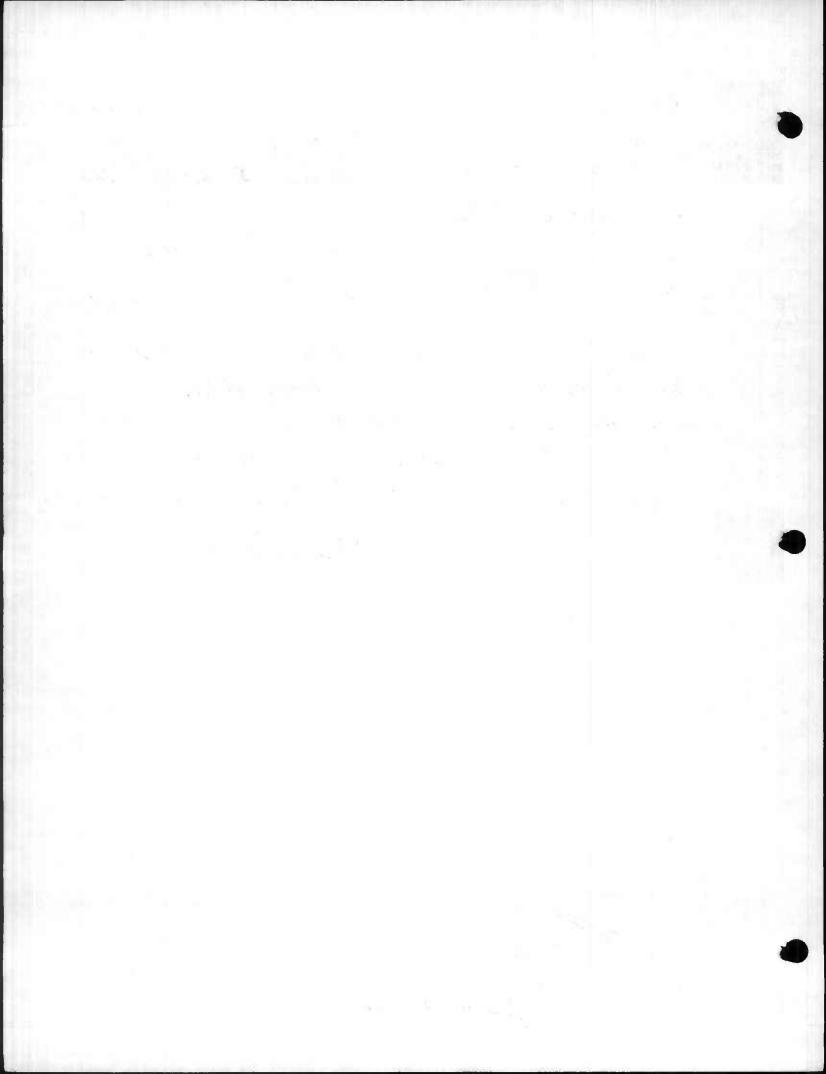
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and menner stated. 29e. Certifler Medical To the Func (Check only one) To the I 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifia: umelen 30. Neme and address of person who completed causa of death (Item 23a) (Type, Print) BELAIR MO EMMONTON RD. SUITE 114-1/4 GREGORY DOHMEIEN 21015 State

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Registrar

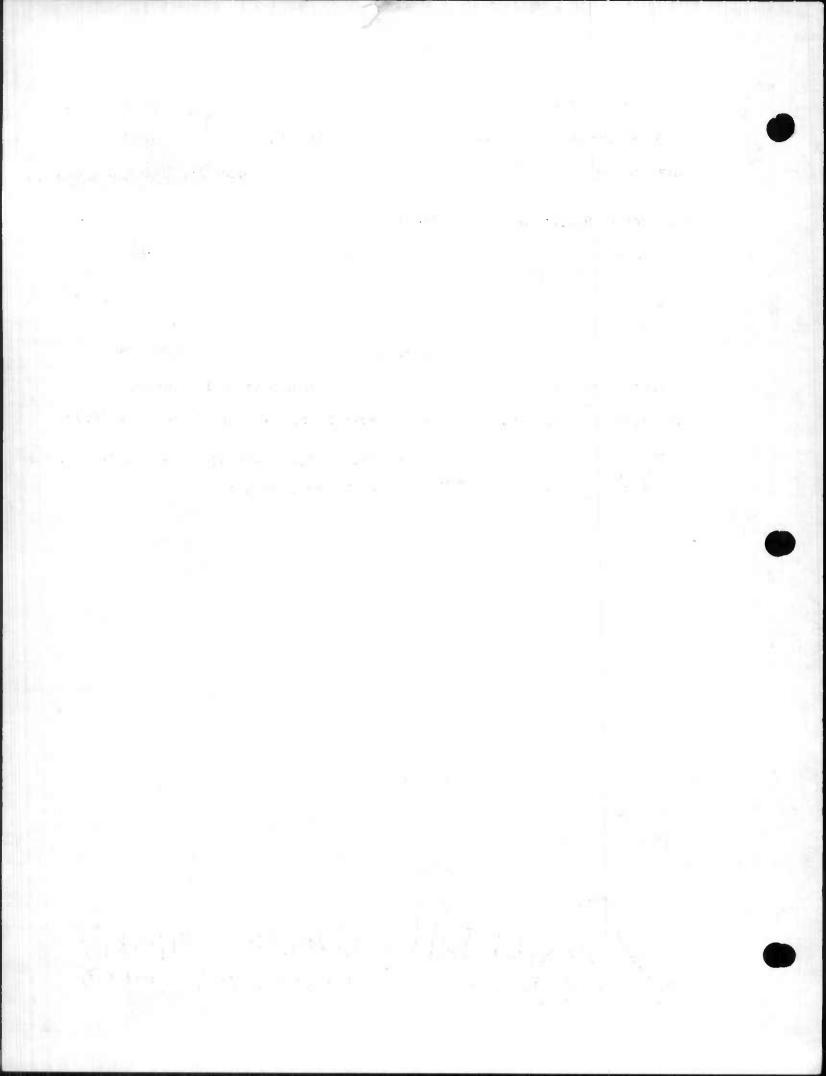
State of Maryland / Department of Health and Mental Hygiene

Physician	_	. Decedant's Name (First, Middle, L.	ast)	1	9 4 4 1			2. Data of De Month	Day	Vaar	ime of Dea
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, or items 23a or 28a-f sho cardinal fraust be notified at by Funeral Director		0e. Street and Number 509 Walker 5	34			2/0			10g. Citizan of V	Vhat Country?	
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State of Maryland / Department of Health and Mental Hygiene

		Decedant's Name (First, Middla, La:	st)		Cer	tificate of	Death	2 Date of Dee			3. Time of De	ath
Physic /Med		LENA FRANCES MALNA	TI .					Septembe	Dey ex 14	1998	8 20 m	,
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Funeral Director	_	017-30-7734	ax □ M 2C] F	ge (In yrs. I. 92	ast birthday) Yrs.	If Undar 1 Yaar Months Deys		8. Deta of Birth (Month, Day June 21	, 1906		lece (State or Fi try) achuset	
dand dand		Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation				1	0d. Inside City L	imits
the Marylar 28a-f show	to	New Jersey Burlin	gton	De	elran						1) Yes 2[] No
th with the 23a or 28	ai Directo	10e. Street end Number 116 Kevin Road				10f. Zip Code 0870	5	1	0g. Citizen of V USA		try?	
within 72 hours after death with the Maryland ens. than "natural", or items 23s or 28s-f show he Medical Examinat mant be notified a	by Funeral	11. Meritei Status 1 Never Marriad 2 Merried 3 Widowed 4 Divorcad	12. Was Decedent Armed Forces 1 Yas 2 A If Yas, Give Yaar or Dates:	Ever in U,S No		Ves Decedent of Yas, specify Cut ☐ Yes ②☐ No	Hispenic Origin? (Spean, Maxican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		e - Amaric k, White, White		
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1 and 2 Health em 27 I		Dr Peter L. Malna 20a. Method of Disposition	tti (Son)	20b. PI		sition (Nema of petory or other pla	anding Rd		20c. Location -			
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permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.		21. Signature of Amerel Service Licen	-	M0017	22.	Name end Addr			2000		3 00,	
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requires that the death cert seen signed by the attendin hould be datached for use	by Physician/N	Total Significant Contantons Co	minibuling to obatin E	out not resu	italy at the dif	uanying causa g	WOI III FOIL I.		es 2 No	3 Prot	11	
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		30. Name and address of person who o	empleted cause of c	deeth (Item	23a) (Type, F	Print)	2000	1.	7/13	M	ς <u>β</u>	



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		ames Henry Hi	.LL, Fa	OOL DI	and of Diago	as #10 sition (Nama of		Dete	20c. L	ocation - City	v or Tow	m. State	
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-			11	11000	Wi	illiams	ress of Fecility Funera	al Home	, P.	.A.			
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State

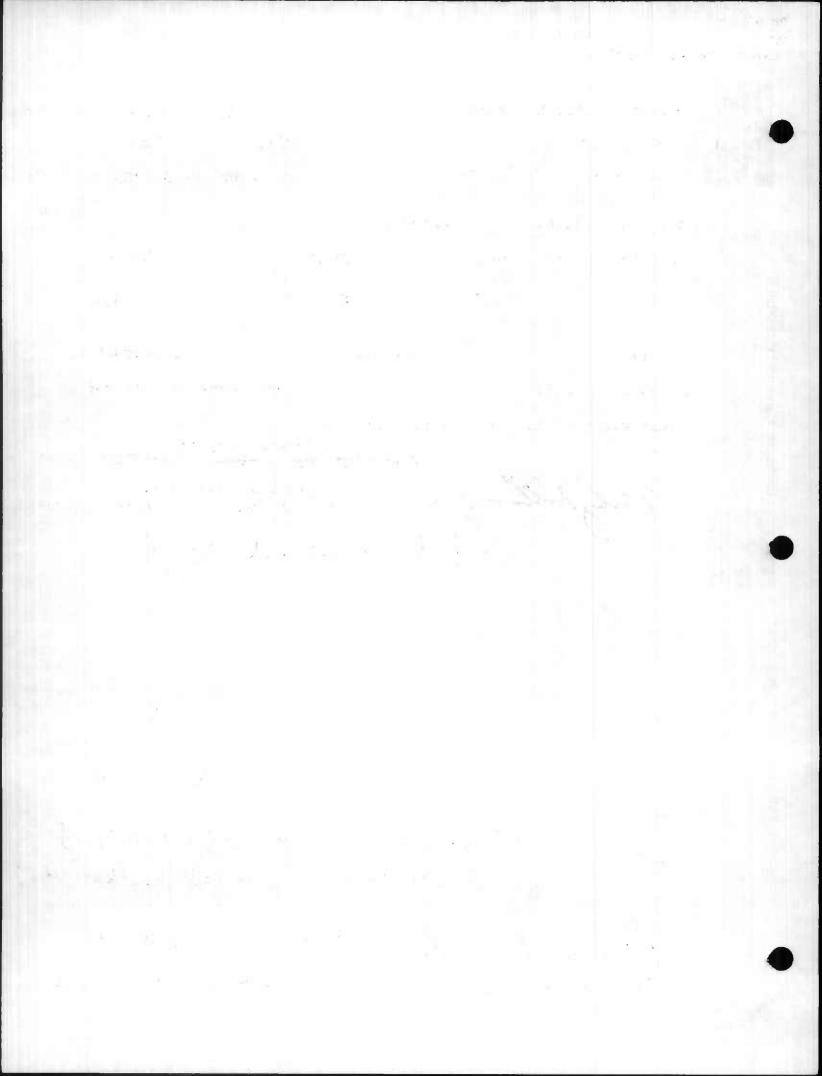
J- LARON (SCEEMS)
31. Data filed (Month, Day, Year) 32. Ragistrer's Signatura

SEP 15 1998

addrass of person who completed causa of death (Itam 23a) (Type, Print)

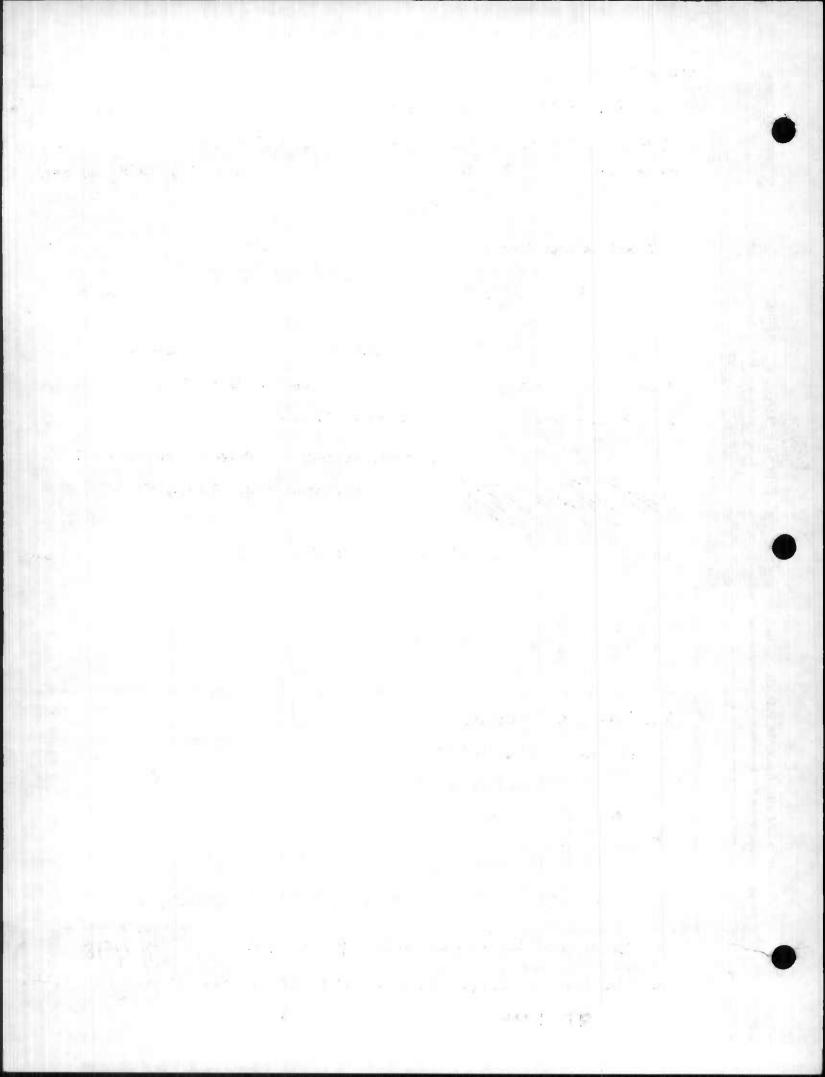
111 Penn Street, Baltimore, Maryland 21201

Registrar



	ephanie Ann May			Centil	icate of	Death	2. Dete of Dec	Reg. No.	3. T	ime of Deeth
ian ical	STEPHAN	VIE		YES		4b. City, Town, or L	Month	Day 13ER 10	1998	3.00 P
ner	4e Fecility Neme (If not institution, git HARBOR HO	SPITAL		TER		BALT			or Death	
	5. Social Security Number 6. 164 66 4608		Age (In yrs. la 18	ast birthday) I	Under 1 Yeer onths Deys	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De)	h	Country)	State or Foreign
	Usual Residence of Decedant 10a. State 10b. County MD			, Town or Locati	on					side City Limits
	10a. Street and Number		Dai		Of. Zip Coda			10g. Citizan of V		Yes 2□No
	40 West Talbot	t Street			TOT. ZIP COGE	21225	5	Tog. Onizali oi v	mat Country !	USA
	1↑. Marital Status 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Detes	? XNo		Decedent of Hos, specify Cube	lispenic Origin? (Sp en, Mexican, Puerto Specify:	pecify Yes or No- Ricen, etc.)	Specify	e - American Ind k, White, etc. white	ien,
	15. Decedent's E (Specify only highest gi			(Give kind	's Usuel Occup d of work done NOT use retired	during most of work	king	16b. Kind of Bu	siness/Industry	
11.0	Elamantary/Secondary (0-12)	Collaga (1-4o	r 5+)		sewife			own h	ome	
	17. Fether's Name (First, Middle, Las Ronald Alan D					18. Mother's Nem Sandra	e (First, Middle, Jean	Maiden Sumem Davis	e)	
-	19e. Informent's Name/Relationship Bryan E. Mayes/h			19b. Malling A		and Number or Rui	ral Route Numbe	er, City or Town,	State, Zip Code,)
	20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Spec		CE	ece of Disposition of	ory or other place		Dete 9-14-98		City or Town, Si	lete
	21. Signeture of Funeral Prvice Lice		3		ame end Addre	ess of Fecility Deral Homo	e, Owin	ngs, MD	20736	
Examiner	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause, (Disease or Injury	e. ST		s e consequer	nca of):	PTICL	2		12	Hours
dical dical	Cause (Dissase or Injury that initiated events resulting in death) Lest	c	Due to (or	es e consequen	ce of):					
and the second s	Pert II. Other significant conditions METABOLIC	contributing to death		Iting in the unde	rlying ceuse giv	ven in Part I.		lobacco use co Yes 2 No	ntribute to the o	
	SEIZURE	DISOR					24e. Wes	en autopsy rmed?	evalleble	on of cause
							10	Yes 2 No	1 ☐ Yas	2 No
	25. Wes cese referred to medical examinar?	Hospitel:			Oth	26. Pleca of Dee				
	1 ☐ Yes 2 No 27. Mannar of Deeth	28e. Dete of In	jury	28b. Time of	3□ DOA 28c. Injui	4 Nursing H		dence 6 □Oth how injury occur		
edicai Certification:	1 Netural 5 Pending 2 Accident 3 Suicide 6 Could not 4 Homicide	on be 28e. Plece of I	njury - At ho	Injury me, farm, streat	M 1 🗆	Yes 2□No	28f. Location (: City or Tox	Street end Numb vn, State)	per or Rural Rou	te Number,
edicai C	29a. Certifier (Check only one) 1 Certifying P	thysician: To the besiminer: On the basis end menner	of examinati	wledge, death od ion end/or inves	curred at tha ti	ma, date end plece opinion, daath occu	, end due to tha rred at tha tima,	ceuse(s) and mo data end place,	enner as stated. and due to the c	ceuse(s)
N.	29b. Signeture end title of certifier	n K. Cen	mph	and.	29c. Licens	2792		29d. Date signe	d (Month, Day,	Year)
	- Levy Co		1					111	1/10	

DHMH 16 Rev 6/95



	Decedent's Nama (First, Middle, Last)		Certificate of	Death	2. Date of Dea	eg. No.	62370
Physician			MACKAL	I., Sr		BER 12,	3. Time of Death 1998 0214
/Medical	JOHN 4a Facility Nama (If not institution, giva stree	at and numbers		4b. City, Town, or Lo		4c. County	
Examiner	Calvert Memorial Ho	spital		Prince Fr		,	lvert
Funeral Director	5. Social Security Number 214–36–3069 6. Sex	2□ F 7. Age (In yrs. last b	Yrs. If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day March 3,	Year)	9. Birthplace (State or Foreig Country) Maryland
how	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limit
o Ma	Maryland Calvert	Prin	ce Frederick				1 ☐ Yes 2 🛣 N
3a or 24	10e. Street and Number 515 Dorsey Road		10f. Zip Code 206	78	1	Og. Citizen of V	What Country?
within 72 hours after death with the Maryland with in Tabours after death with the Maryland ene. Ne Address Exeminer must be notified at mapleted by Funeral Director	11. Merital Stetus 1 Nevar Married Married	Wes Decedent Ever in U,S. Armed Forces? I ∐ Yes 2 ☒ No If Yes, Give Year or Detes:	13. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bled	e - American Indian, sk, Whita, etc. - Black
filed within 72 hours of the Wysiens of the Whysiens of our first than 'natural', or out, the Western Exercises.	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondery (0-12)	on mpleted) College (1-4or 5+)	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Custodian	during most of work d)	ing		Ling Co.
	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Maiden Sumam	pe)
2 should be filed within and Mental Hygiene. In marked other than aumatic event, the LTO Be Comp	Andrew	Mackal1		Eva M	ae Ky	ler	
2000	19a. Informent's Neme/Relationship (Type, i		b. Meiling Address (Street				
C = N L	Virginia Mackall/Nie		15 Dorsey Ro	ad Prin	-		4D 20678
8 2 2 0	20a. Method of Disposition **Dispurial 2 Cramation 3 Ramo 4 Donation 5 Other (Specify)	oval from Stata cemete	or Disposition (Name or or other plant of or other plant) Live UMC Cem				City or Town, Steta Frederick, MD
permit. Page Department of Important: If eny Injury or pnce.	21. Signatura of Funerel Sarvice Licensee **Desdessar G. Service Licensee**	well	22. Name and Address 1451 Dares		well Fur . Princ		ome erick, MD 2067
at the death certificate be executed The death certificate be executed The attending physician and etached for use as the burial-transit Thysician/Medical Examiner	Immediate Ceuse (Final disaase or condition resulting in death) a	Due to (or as a	CONSEQUENCE OF): a consequence of): a consequence of): consequence of):			20	
death death of for selected	Part II. Other algnificant conditions contribu	uting to death but not resulting	in the underlying cause git	ven in Pert I.	23b. Did to	obacco use co	ntribute to the cause of death
£ X 13					1 🗆 Y	es 2 No	3 Probably Unknow
aw requir					24a. Was a perfor		24b. Were auropsy findings available prior to completion of ceuse of death?
The Late he page					1 D Y	es 20 No	1 ☐ Yes 2 ☐ No
certificate irector, pag	25. Was case refarred to medical examiner?			26. Place of Deat	h (Check only or	10)	
the sign of	1	1 LI Inpatient 2 LI EH/O	Time of 28c. Injury Wo		me 5 Resid 28d. Describe h		
the the	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	8e. Plece of Injury - At home, 1 building, etc. (Specify)		7195 2 110	28f. Location (S City or Tow		per or Rural Route Number,
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff	(Check only 2 Medical Examiner:	n: To the best of my knowledg On the basis of examination a end manner stated.	ge, death occurred at the ti nd/or investigation, in my o	me, date and place, opinion, death occur	end due to the c red at the time, o	ause(s) end me late and place,	enner as stated. and due to the cause(s)
withir To th comp	29b. Signatura and titia of complet		29c. Licens	~	2	29d. Date signe	d (Month, Day, Year)
	W		Da	29651		9/13/	198
9	30. Name and address of person who complete Dr. Charles Judge	M.D., Prince E	(Type, Print) Frederick, Ma	aryland 2	20678	-1/-/	
State Registrar	31. Dete filed (Month, Dey, Year) SFP 1 5 19	32. Registrar's Signeture	B. 6.	arka)			

State of Maryland / Department of Health and Mental Hygiene 2 9 3 7 9

ysician	1 5 1 1 11 11				OCI	rtificate (UI Dea	un		Reg. No.		
veician	1. Decedent's Nam	e (First, Middle, La	ast)						2. Dete of De Month	eth Day	Year	3. Time of Death
Medical aminer			se McBee)			4b. City	, Town, or L		ber 10,	1998	1:06 pm
ammici	Washingt	on Adven	tist Hospi	ital			Tak	coma P	ark	Montg	gomery	
eral ctor	5. Social Security N 213-12-19	148 6.5		ge (In yrs. la 78	est birthdey) Yrs.	If Under 1 Y Months Da	ear If Ur ays Hou		8. Date of Bir (Month, De May 18	th ey, Yeer) , 1920	9. Birthplac Country Wyom:	ce (Stete or Foreign ing
	Usual Residence of	Decedent 10b. County		10c City	, Town or Lo	ncation					10d	I. Inside City Limits
JO JO			01-	Too. Only,							100	1 ☐ Yes 2 📉 No
Director	Maryland 10e. Street and Nu		George's		A	delphi	de		T	10g. Citizen of V	What Country	17
			Desire				20783			U.S.A		, .
once. To Be Completed by Funeral Director	11. Meritel Stetus 1 Never Marr	rnedale	12. Wes Decedent Armed Forces' 1 Yes 2 If Yes, Give	t Ever in U,S ? [No			of Hispenic Cuben, Mex		pecify Yes or No o Rican, etc.)		e - American ck, White, etc	
d by	3 🖾 Widowed	4 Divorced	Yeer or Dates:								Whit	
Completed	(Spec	15. Decedent's E cify only highest gr	ducation rede completed)		16a. Deced	dent's Usual Or kind of work di DO NOT use re	ccupation one during	most of wor	king	16b. Kind of B	usiness/Indus	stry
d E	Elementary/Seco	endary (0-12)	College (1-4or	5+)			etirea)			0 77		
ပိ	12 17. Father's Name	(First Middle Lest	1)		nome	maker	18. M	fother's Nam	ne (First Middle	Own Ho		
Be			lson									
Lo	19a. Informant's No				10h Mailir	na Addrass (St				n Gilber, City or Town,		(ode)
	Thomas W.									i, Maryl		20783
	20a. Method of Dis		3011	20h Ple	ace of Dispo	sition (Neme o	of	LIVE,	Date	20c. Location		
			Removal from State	Cei	metery, crei	metory or other	r plece)				,	,
once	21. Signature of fu	K	111			2. Name and A Sasch's		,	****			
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State

Registrar

31. Date filed (Month, Dey, Yeer)

SEP 1 1 1998

Amondod #2	5. Per Doc. PGC 9-1			epartment of F Certificate of			2.0	29380					
Amended #2.	1. Decedent's Name (First, Middle, Last)		201111100110 01	Douin	2. Date of De Month	Dey Ya						
/Medical	PAMELIA PATRICIA M 4e Facility Name (If not institution, give				4b. City, Town, or Le		BER 7,1998						
Examiner	PRINCE GEORGES COM		ΕΡΤΤΔΙ.		CHERVERL		PRINCE						
Funeral	5. Social Security Number 6. Se		(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Dete of Bir (Month, De		Birthpleca (State or Foreign Country)					
Director	577-80-2856	JM 2ĬX F	41 Y	s. Months Days	Hours Min.			SHINGTON DC					
10-1-9 }	Usuel Residence of Decedent 10a. State 10b. County		Oc. City, Town	or Location				40d Inside City I imite					
5 23	MD PRINCE GE			DENSBURG				10d. Inside City Limits 1X Yas 2 No					
or 28a-f s he notified Director	10e. Street end Number	1		10f. Zip Code			10g. Citizen of What	Country?					
	5006 57th AVE			20710			UNITED S'						
ther death riber 234 diper ment	11. Marital Stetus	12. Wes Decedent Ev	er in U,S.	13. Wes Decedent of I	lispanic Origin? (Sp	ecify Yas or No		Vmarican Indian,					
020 our atter st, or he Examine by Fur	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes:		If Yes, specify Cub	Specify:	Hican, etc.)	Specify:	Vhite, etc. BLACK					
72 ho Meature	15. Decedent's Edu (Specify only highest grad		16a. D	Decedent's Usuel Occup Give kind of work done	pation during most of work	ina	16b. Kind of Busine	ess/Industry					
1.21215-0 sid within 72 ho righere. wer than "neutum It, the Medical	Elementary/Secondary (0-12)	Cpllege (1-4or 5+)	1	ile. DO NOT use retire MINISTRATI	d)		PRIVATE						
d 2 Hithed 2	17. Father's Nema (First, Middle, Last)						, Maiden Sumeme)						
ylan Mental Mental Mental To Be	HUBERT McDONALD				MARY C		, , , , , , , , , , , , , , , , , , , ,						
Mary 2 sho 1 s mary 1 s mary	19a. Informent's Name/Reletionship (7) MARY E. LEWIS/ MC			Weiling Address (Street				te, Zip Code) 0009 APT 20					
	20a. Method of Disposition	Inek		Disposition (Name of	L SI N.E.	Dete	20c. Location - City						
0 85 8	f Burial 2 ☐ Cremation 3 ☐ F		cemetery.	cremetory or other ple									
Baltim pemit. Pa Department important any fujury ance.	4 □ Donetion 5 □ Other (Specify) 21. Signature of Funerel Service Licens			LINCOLN CE	ess of Fecility	9-12-98							
B S S S S S S S S S S S S S S S S S S S	21. Signature of Funerel Service Licenses ### 22. Name and Address of Fecility ALEXANDER S. POPE FUNERAL HOME												
	5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part I. Enter the disease or complications that be used the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate												
Physician /Medical Examiner	Immediate Cause (Finel disease or condition	cause on each line.	ps	25	4			Interval Batween Onset and Death					
	resulting in deeth)	O Di	ue to (or as a	nsequence of):	/								
owcuted in end tal-transit		Kon	rat	Fail	ure								
60, be executed ician end burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	De	ue to (or es e co	nsequence of):				1					
a price & OC	that initieted events	Du	ie to (or as a coi	nsequence of):									
Med the	resulting in death) Last												
BOX 68 beth certific ettending pl for use es t		d											
P.O. Box 6876(nat the death certificate be d by the ettending physicia letached for use set the bur	Pert II. Other significant conditions con	ntributing to death but	not resulting in t	he underlying cause gi	ven in Part I.	23b. Did	tobacco use contrit	outs to the cause of death?					
	Sleep (Upn	ea			10	Yes 2 No 3	Probably Unknown					
of Vital Records, Physician: The law requires this certificate has been signs and director, page 2 should be at To Be Completed by								4b. Were eutopsy findings available prior to					
I Record The law requin sate has been signage 2 should Completed						penc	ormed?	completion of cause of death?					
The law ate has page 2.						10	Yes No	1 ☐ Yes 2 ☐ No					
f Vital II	25. Wes case referred to medical				26. Place of Deet	h (Check only	one)						
Of V Physics this ce al dire	100 100 ST NO	lospitel: Inpatient		attent 3LI DOA			dence 6 Other (Specify)					
On O ding Ph h. After th funeral	27. Magner of Death 1 △Natural 5 ☐ Pending	28a. Date of Injury (Month, Dey)	(ear) 28b. Tin	ury Wo		28d. Describe	how injury occurred						
Vision Attending of death. ector: Afte by the func	Accident investigation 3 Suicide 6 Could not be	29a Plans of Injury	At home form	M 1 C	Yes 2□No	28f Location /	Street and Number of	r Rurel Route Number,					
Division or Attending effer death. Director: Affer the tune ertification	4 ☐ Homicide determined	building, etc.	(Specify)	i, street, factory, onice		City or To		7 1310 7 10310 113111001,					
Hospital A hours Funeral tely filled IICal C			camination and/	death occurred at the ti or invastigation, in my (
To the comple	29b. Signature and title of certifier	wito maising state		29c. Licens	se number		29d. Date signed (N	forith (Nily, Year)					
- FFO	VI	-		na	0315	2	9/7	198					
	30. Name and address of person who or	empleted cause of dea	th (Item 23a) (T	ype, Print)	,		11/						
	James Catav	enis, M.	D. 3	3001 Hose	rital Di	2. (h	everly n	10 20785					
State Registrar	31. Date filed (Month, Day, Year) SEP 1 1 1998	32 Registrer	Signature &.	Son V	_		7						

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State of Maryland / Department of Health and Mental Hygiene 98 2938 |

		Genificate of	Death	Reg.	No.			
1. Decedent's Name (First, Middle, La Sician Marguerit	e Elizabeth Bu	rns McCrimmon		2. Dete of Death Month eptember		3. Time of Deeth 12:40 P.M		
ledical 4a Facility Nama (If not institution, given			4b. City, Town, or Local		4c. County of E			
Southern Maryl	and Hospital		Clinto	n	Prince	Georges		
5. Social Security Number 6. S	Sex 7. Age (In yrs. I	Months Day	s Hours Min.	B. Dete of Birth (Month, Day, Ye	9. 9ar)	Birthplaca (Stata or Foreign Country)		
Usual Residence of Decedent	86	Yrs.		January	4,1912	North Carolina		
10e. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits		
8	Georges	Clinton		40-	China at Man	1 Yes 2 No		
10e. Street and Number 9106	Pine View Lane	20.	735		10g. Citizen of What Country? United States			
Future Care/Pine 11. Marital Status 1 Never Married 2 Married	View Nursing H	ОШЕ				American Indian,		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates:	If Yes, specify Cu	Hispanic Origin? (Speciban, Mexican, Puerto Rose Specify:	ican, etc.)		White, etc. Black		
15. Decedent's E		16a. Decedent's Usual Occ	upation	168	o. Kind of Busine	ass/Industry		
(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of work don life. DO NOT use reti	e during most of working red)	9		The state of		
11th grade	555J0 (1 461 57)	Beauticia	an		Self-Em	ployed		
17. Father's Name (First, Middle, Last,)		18. Mother's Nama	(First, Middle, Mai	den Sumame)			
Thomas	Burns		Sarah		Johns	on		
19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stre	et and Number or Rural	Routa Number, C	ity or Town, Sta	te, Zip Code)		
Mary McCrimmon-Ca		1	e Way, Alex					
20u. Method of Disposition 1XXBurial 2 Cremetion 3 C 4 Donation 5 Other (Specif	Removel from State	tace of Disposition (Name of emetery, crematory or other p yland Nationa		1998		y or Town, Stete		
21. Signature of Funeral Service Lice		22. Name and Add	lress of Facility Robe	rt G. Ma	son Fun	eral Home, Inc n, D.C. 20020		
23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.					Approximete Interval Between		
						Onset and Death		
Immediate Cause (Final disease or condition resulting in death)	GENERA	17ED SEF	SIS			2 WKS		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consequence of):						
	b							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	r as a consequence of):						
that initiated events	C. Due to for	r as a consequence of):						
resulting in death) Last	d	as a consequence orj.	5					
Part II. Other significant conditions of	contributing to death but not	illing in the underlying gaves	niven in Pert I	23h Did toha	cco use contril	bute to the cause of death?		
		my m are unconying cause (g.v. arr wir OIL I.			Probably 4 Unknown		
RENAL FAILUR	E				20140			
DIABETES M	ELLITUS			24a. Wes an a		4b. Were autopsy findings evailable prior to		
				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		completion of cause of death?		
CORONSRY AR	TERY DISE	F		1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No		
25. Was case referred to-medical	/		26. Place of Death	(Check only one)				
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Wher	e 5 Residenc	e 6 Other /	Specify)		
27. Manne of Death 1 Natural 5 Pending investigation	28a. Data of Injury (Month, Day Year)	28b. Time of 28c. to W		8d. Describe how				
2 Accident Investigation 3 Suicide 6 Could not be determined	e con Diago of John At he		Bf. Location (Stree City or Town, S		or Rural Routs Number,			
(Check only 2 Medical Exam	nyelclan: To the best of my knowning.							
29b. Signature and title of pertifier	and manner stated.		nse number			Aonth, Day, Year)		
with.	2/ms		12213	290.		34/98		
30. Name and address of person who		o of death (Hem 23a) (Type, Print) 0 - 10 ST. PATRICK'S DRIVE, #502, WALDOKF, MD. 20603						
31. Date filed (Month, Day, Year)			-11-502	WA-JUL	1 100			
01. Date med (moner, Day, 1001)	Troylatial a cityria							

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Registrar

SEP 0 0 1998

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** MARY KATHLEEN MAURER 10:25 AM 1998 August 31 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 26380 Old State Road Crisfield Somerset If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Deys 1□ M 20 F 83 213-05-8460 Yrs. Director Maryland Sept. 17,1914 Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exprimer must be notified at Crisfield 1 ☐ Yes 2 No Director Maryland Somerset 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? with 26380 Old State Road 21817 USA death \ Funera 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 월 No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 11 Meritel Stetus 2 should be filled within 72 hours after n and Mental Hygiene.

Is marked other than "natural", or its 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3X Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary Clothing Mfg. 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be William James Wilson Lucy Jane Lawson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trai 26380 Old State Road - Crisfield, MD Phyllis J. East (daughter) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremetion 3 Removel from State Crisfield, MD 4 ☐ Donetion 5 ☐ Other (Specify) Sunnyridge Memorial Park 9/8/98 22. Name end Address of Fecility

Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817 Robert H. Bradshaw 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsel end Death **Physiclan** /Medical Immediate Ceuse (Final 1 " Theroschuctic Cardiovascular Disease diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner ician and burial-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): physician s s the burial-Box 68760. 90 Physician/Medical Due to (or es e consequence of): 88 9SD for Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Records, P.O. the deteched 23b. Did tobacco use contributs to the cause of death? signed by t Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 24e. Wes en autopsy performed? Completed peeu page 2 hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: after death. 25. Was case referred to medical 26. Piece of Deeth (Check only one) 8 Hospital: 1 ☐ InpatIent 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 this funeral 28e. Date of Injury (Month, Day Year) 27. Menger of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29e. Certifier 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner as steted. Medicai (Check only one) 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. within 2 To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 en 1 D 48098 Sept. 2, 1998 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State books SEP - 8 1998 Registrar

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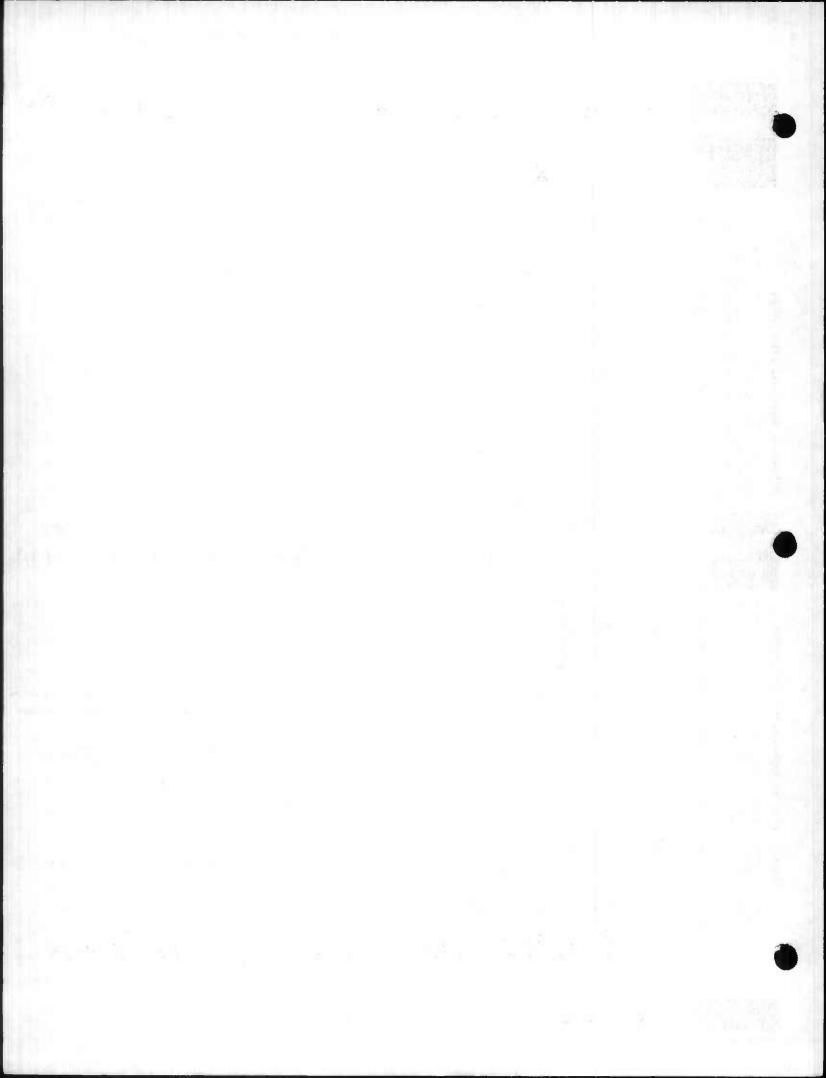
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State of Maryland / Department of Health and Mental Hygiene

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> CUCOU 11 MD D16354 SEPT 3 19	4 Unknown utopsy findings a prior to ion of cause? 2 No
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Enser W. Cole III M.D. 900 Bestgate Rd. Annapolis, Md. 21401	4 Unknow utopsy findings a prior to ion of cause ? 2 No the Number, cause(s)



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			1. Decedent's Name (First, Middle, L.	ast)			,	-		2. Dete of De			Time of Death	
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	Examine		4a Facility Name (If not institution, gi					4	b. City, Town, o	r Location of Death	4c. County			
	Funeral Director					lest birthday 9 Yrs.	Months E	Year	Takoma If Under 24 Hi Hours Mi	s. 8. Date of Birt	th y, Year)	9. Birthplece (Country) Nige	Stete or Foreign	
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020	urs after	by Funeral	11. Marital Status Securated 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		S. 13.	Was Deceden if Yes, specify 1 ☐ Yes 2	Cube	spanic Origin? in, Mexicen, Pue Specify:	Specify Yes or No into Rican, etc.)		e - American Ind ck, White, etc. c: Blacl		
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and	be fill d oth	Be	17. Fether's Name (First, Middle, Las						18. Mother's N	ame (First, Middle,	Maiden Suman	10)		
Maryland	les 1 end 2 of Health e f Item 27 is or other tre		Alfred Chukuwk 19a. Informant's Name/Relationship Theodora Nwanl	(Type, Print)					and Number or i	dora U. Rural Route Numbe Dr. Silv	er, City or Town,	State, Zip Code	20906	
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removel from State	C	lace of Disp emetery, cre	osition (Name metory or othe Cemete	of er plac	э)	Date 9/22/0	20c. Location - AWk	City or Town, Sta, Ana		
Balt	permit. Pag Department Important: I any injury o		21. Signeture of Funerel Service Lice **Dianda C.** 23a. Part1. Enter the disease, or corshock, or heart failure. List only				2. Name and A W.H. I 3447			eral Ho	ome, In	c.		
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Division o	Attanding Pi	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Sulcide 6 Could not	28e. Dete of Injury (Month, Day Yeer) 28b. Time of Sec. Injury at Work? 1 Yes 2 No						how injury occur				
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	To the comple	×	29b. Signature and title of certifier	tuy my)	1			-403 Whingto		29d. Date signe 9/4/		Year)	
	(5)		30. Name and address of person who	n oc										

33 Registrar's Signature G. Sparks

DHMH 16 Ray 6/95

State Registrar 31. Dete filed (Month, Day, Year) SEP 0 9 1998

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	1. Decedent's Neme (First, Middla, Last)							Month Dey Year		3. Time of Deeth		
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Examiner	4a Fscility Name (If not ins				1		01ne			nty of Death Montgo		
Funeral Director	5. Social Security Number 577–40–0662	6. S		7. Age (/	n yrs. last birti	hday) If Under 1 Year Months Days	r If Under 24 Hr	s. 8. Dete of B		9. Birth	place (Stata or Fore ntry) ington D.	
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or 28a-f a be notified Director	10e. Street end Number					10f. Zip Code			10g. Citizen	of What Cou	ntry?	
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	19a. tnforment's Neme/Rel				19b.	Mailing Address (Street					p Code)	
17.	Kathleen Kic	herer	- Dau	ghter	100	099 Dudley	Drive,	Ijamsvi	lle, Ma	ryland	1 21754	
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Apriliating liftinger hillian each

Physic

Funera

Director

/Med Exam

Physician /Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

29386

1	1. Decedent's Neme (First, A ADEBIMPE O	DUMUY						2. Date of De Month	/ Day	Year 98 6:45
1	4a. Fecility Name (If not insti Doctors Com				7		4b. City, Town,	or Location of Deeth	4c. County	of Deeth
	5. Sociel Security Number 579–98–8170	6. Se			s. lest birthday) 1 Yrs.	If Under 1 Yes	or If Under 24 H	Irs. 8. Dete of Bird in. (Month, De	th y, Year)	George's 9. Birthplace (State or Foreig Country) Nigeria, W.A.
	Usual Residence of Decedar 10e. State 10b. Co Florida Dad	unty		10c. C	City, Town or Lo	cation		Decaliber	27, 1330	10d. Inside City Limits
-	Florida Dad 10e. Street end Number 15031 S.W.		Lane	MI	ami	10f. Zlp Code 33193			10g. Citizen of V	,
	11. Marital Status 1 Never Married 2 3 Widowed 4 Divo	Married	12. Was Dece Armed For 1 Yes If Yes, Giv Year or De	rces? 2 🔯 No e		Was Decedent o	Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Rec	a - American Indien, ck, White, etc.
	15. Dece (Specify only h Elamantary/Secondary (0-		cation le completed) College (1 4+	-4or 5+)	(Give	lent's Usuel Occ kind of work don DO NOT use rati	e during most of v red)	vorking	16b. Kind of Br	usiness/industry
	17. Fethar's Name (First, Mic Jimoh Odu	ddie, Last) muy i w	a					lame (First, Middle, at Odumuy		70)
	19a. Informent's Neme/Rala Boladale Aiy			er				Rurel Route Numbe		State, Zip Code) land 20770
	20a. Method of Disposition 1 Burial 2 Cremet 4 Donetion 5 Othe	tion 3 🖎 F	Removel from S	20b.	Plece of Dispo cametery, crem an Ceme	sition (Name of netory or other p	lece)	09717		City or Town, State Nigeria, W.A.
	23a. Pert1. Enter the diseas shock, or haart failure.	e, or compl List only of	icetions thet cane cause on e	aused the dea	74	74 Land	over Roa	ERAL HOME d, Landov lec or respiretory er	er. Mar	yland 20785 Approximete Intervel Between Onset end Deeth
	Immediate Ceuse (Finat disease or condition resulting in death)		0		SHOO (or es e conseq		i D Ma i A	7		3 DAYS
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	rasulting in death) Lest	L	URO.		s 1 S	uenca of):				10 DAYS
-	Pert II. Other elgnificant con	ditions cor	ntributing to de	ath but not re	sulting In the ur	ndarlying cause	given in Part I.		lobacco use co	ntributa to the cause of death
							7	24a. Wes	en eutopsy med?	24b. Were autopsy findings eveileble prior to
								101	res 2 No	completion of cause of deeth?
	25. Was case referred to me exeminer? 1 ☐ Yes 2 ☑ No		Hospitel:	npatient 2	☐ ER/Outpetien	t 3D DOA	Mhon	Peath (Check only on Home 5 ☐ Resid		er (Specify)
-	27. Manner of Death 1 Naturel 5 Pa 2 Accident	estigation		of Injury h, Dey Year)	28b. Time of Injury	28c. in		T	now injury occur	
	4 ☐ Homicide da	ould not be tarmined	buildin	ig, atc. (Spec	ify)	eat, fectory, offic		City or Tox	vn, Stete)	er or Rural Routa Number,
	(Check only 2 Med	icai Exami	nar: On the ba end menn	sis of axamin	owledge, daeth ation end/or Inv	estigation, in my	opinion, daath oc		data and ptaca,	end due to the causa(s)
	29b. Signeture and title of ce	rifle	D.			2	nse number		29d. Dete signe	d (Month, Dey, Year)
-	30. Nema and address of per	son who co	omplated causa				7	EEMBELT	M	10

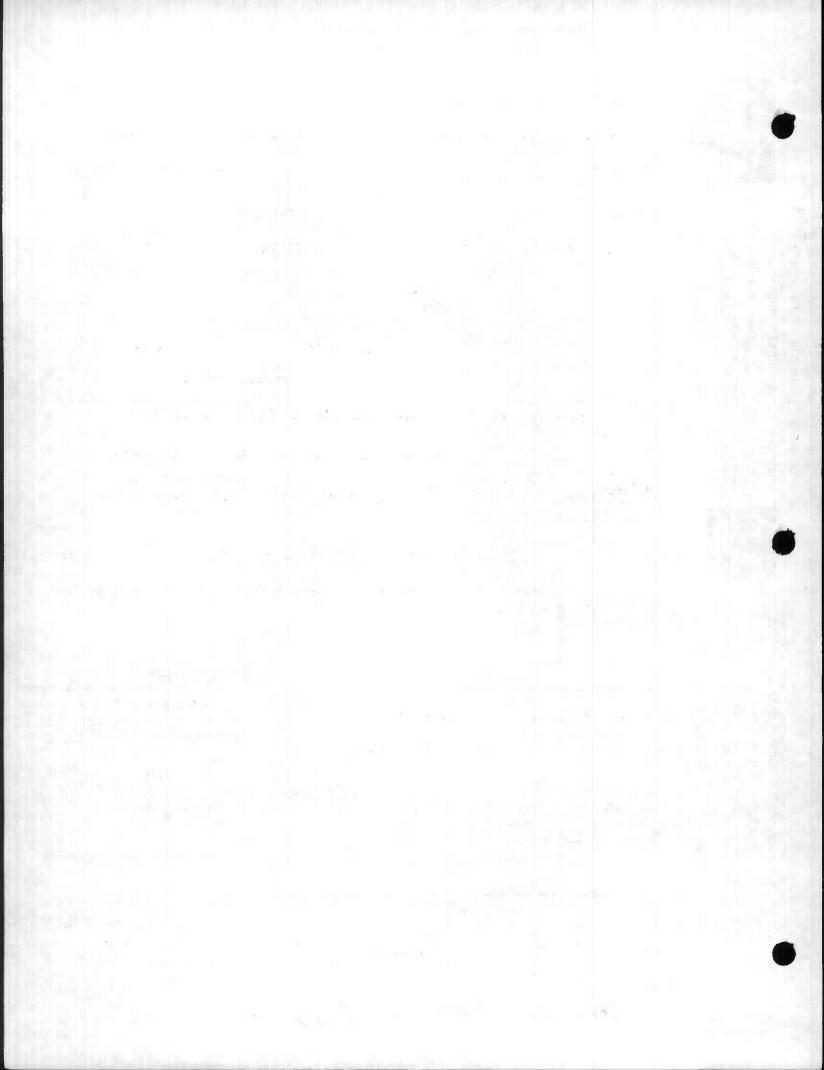
B. Spale

DHMH 16 Rev 6/95

Registrar

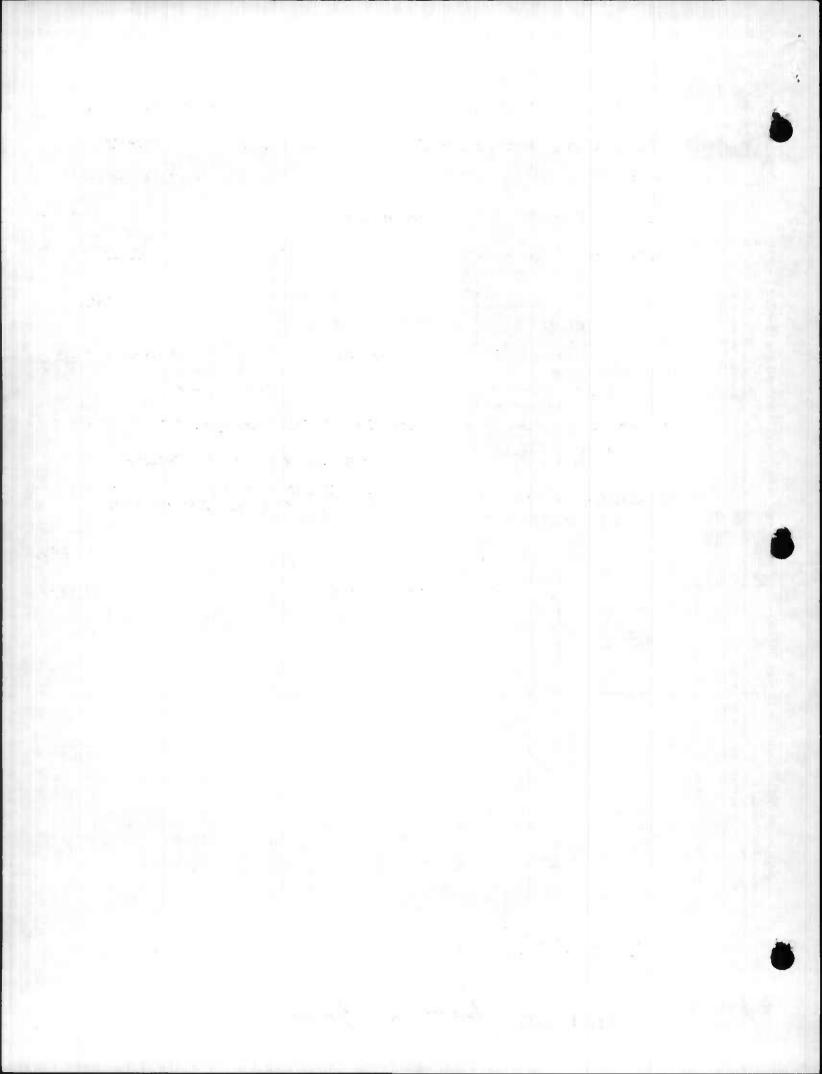
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		Cei	artment of I rtificate of	Death		g. No.		2001		
hysician	1. Decedent's Neme (First, Middle, Last) MARTIN HERSH ORLOVE			100	2. Dete of Deet Month	Dey	Yeer 98	3. Time of Death		
Medical xaminer	4e Fecility Neme (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPI	TAL		4b. City, Town, or WESTMI		4c. County	of Death			
ineral rector	017 OC 2000 154 20E	yrs. last birthdey) Yrs.	If Under 1 Yeer Months Deys			, 1930	Coun	lece (State or Forei try) RYLAND		
	Usual Residence of Decedent	A1 T								
notified at		c. City, Town or Lo	ocation	HAMPSTE	ZND.		1	0d. Inside City Lim 1 ☐ Yes 2121		
Director	MARYLAND CARROLL 10e. Street end Number		10f. Zip Code	TIAMESTE		Og. Citizen of V	that Coun			
ā	1003 Scarlet Oak Ct. Apt 1A		101. Zip 0000	21074		US		.,,		
Funeral	11. Maritel Stetus 1 Never Merried 2 Merried 12. Wes Decedent Ever Armed Forces? 1 Never Merried 2 Merried	1051	Was Decedent of I If Yes, specify Cub 1□ Yes 25(No	Hispenic Origin? (Seen, Mexicen, Puer Specify:	Specify Yes or No- to Rican, etc.)	Bied	k, White,	en Indien, etc.		
d by	O Minderson A STOMMAN NO. 1	1954	1 162 35740	эреспу.		Specify	W	HITE		
Completed	15. Decedent's Education (Specify only highest grade completed)	16e. Dece	dent's Usuel Occu kind of work done	petion during most of wo d)	rking	16b. Kind of Bu	siness/Inc	dustry		
dE.	Elementery/Secondary (0-12) College (1-4or 5+)		STORE OWN			ELEC	TRON	ICS		
	17. Fether's Neme (First, Middle, Last)		JULE OWN		me (First, Middle, A					
To Be	LOUIS CAPLAN			BESS						
-	19e. Informent's Name/Relationship (Type, Print) DONNA L. FRITZGES, DAUGHTER				urel Route Number MPSTEAD,			Code)		
	20e. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removei from State 4 ☐ Donetlon 5 ☐ Other (Specify)		osition (Neme of metory or other ple CREMATIC		Date 1	20c. Location -				
D0000	21. Signeture of Funeral Service Licensee	· e 22	2. Name end Addre		ELINE FUN T, HAMPST			74		
	23a. Part1. Enter the diseese, or complications that caused the shock, or heart failure. List only one cause on each line.	deeth. Do not en					210	Approximete Interval Between		
/ Physician/Medical Examiner	if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	to (or as e consec	quence of):	ARDIO V	ASCULAR	DISEA	25/8	YEARS		
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ysk	Pert II. Other algnificant conditions contributing to death but no	ot resulting in the u	nderlying cause gi	ven in Pert I.	23b. Dld to	/		the cause of dec bably 4 Unkr		
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Be	25. Wes cese referred to medicei examiner?				eth (Check only on	e)				
2	1 ☐ Yes 2 @ No Hospitel: 1 ☐ Inpatient	2 ER/Outpatie	IL SLI DOA		Home 5 Reside		-	y)		
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Certifi	3 Suicide 6 Could not be determined 28e. Plece of Injury building, etc. (S	At home, ferm, st Specify)	reet, factory, office		28f. Location (St City or Town	reet end Numb n, Stete)	er or Rure	Houfe Number,		
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exe end menner steted.	minetion end/or in								
×	29b. Signature and title of certifier	a ma	1	se number	2	9d. Date signe 9 / 3	d (Month,	Day, Year)		
	30. Name and address of person/who completed cause of death (flem 23a) (Type, Print) GOGC WASHINGTON RD									
j.	VINCENT T. FIDELO	T								



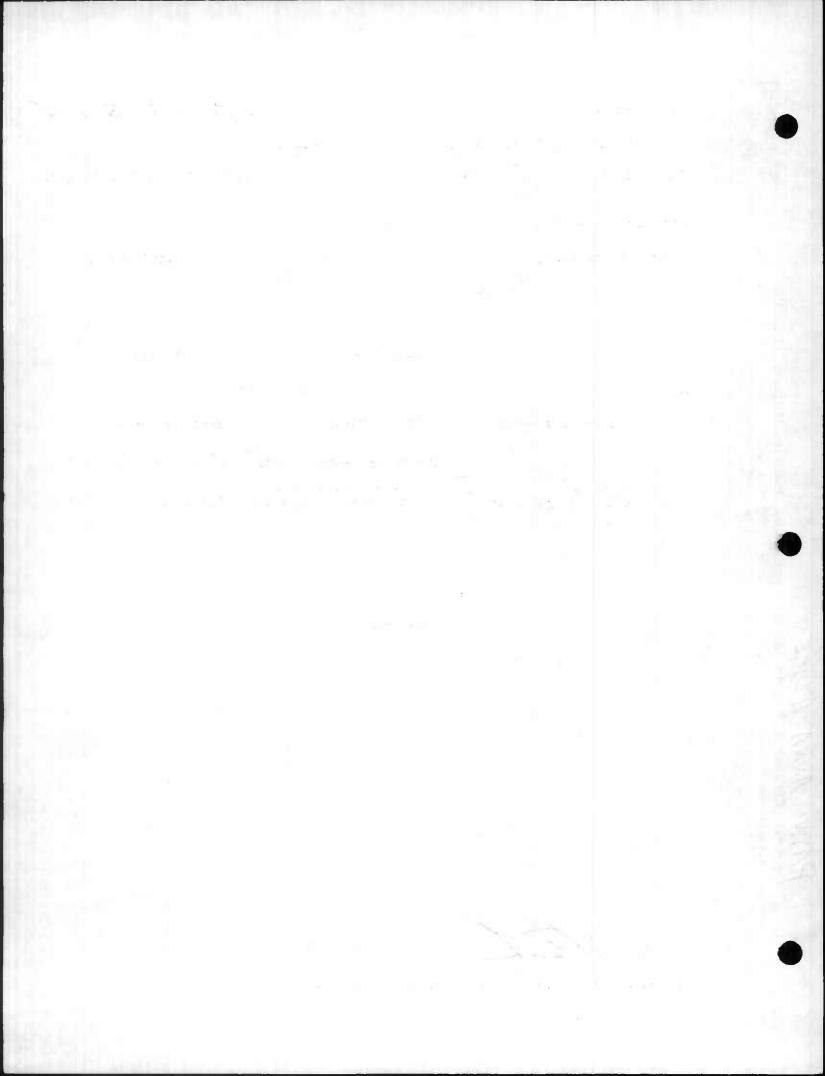
11 /	per F.D. 9/10/98 (1. Decedent's Name (First, Middle, Li			Certifica	ie oi L	Jeaur	2. Dete of De		9	3. Time of Dea
ician dical			Orr			0: 7	_		1998	6 Am
ainer	4a Facility Name (If not institution, gh	Mary			4	b. City, Town, or L		1		
al	5. Social Security Number 6.		Hospital Age (In yrs. lest birtho	feet If Und	er 1 Year	Westmins If Under 24 Hrs.			roll	lana (State or En
	219-05-0612	1 X M 2 □ F	76 86 Yrs	A A Ab -		Hours Min.	8. Date of Bird (Month, Da Feb 10	y, Year)		lace (Stete or Fo try) Land
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location					1	0d. Inside City Li
0	MD Carro	211		esvil	le					1 ☐ Yes 2.
Director	10e. Street and Number				ip Code		- 1	10g. Citizen of V	What Coun	itry?
	2106 Country 1	Fair Lane				21784			.S.A.	•
runerai	11. Marital Status	12. Was Decede	nt Ever in U,S.	13. Wes Dec	edent of Hi	spanic Origin? (Si	pecify Yes or No	- 14. Rac	e - Americ	
-	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date:	XNo		ecity Cuba 2∏No	Specify:	Hican, etc.)	Specify	ok, White, Whi	
	15. Decedent's E		16a. D	ecedent's Us	ual Occupa	ition	Line	16b. Kind of Be	usiness/ind	dustry
חוווחופופת	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4c	- Ii	fe. DO NOT	use retired,	funing most of wor	KIIII			
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2	17. Fathers Name (First, Middle, Las.	()				18. Mother's Nan		Maiden Suman	10)	
0		obert Or					ive Jan		-	0.41
	19a. Informant's Name/Reletionship					and Number or Ru		-		
	Mrs. May E. Orr	(Wite)	20b. Place of D			Fair La	ne Sykes	20c. Location -		
	1 ☐ Burial 2 ☐ Cremation 3 [te cemetery,	cremetory or	other pleci					
	4 Donation 5 Other (Special Signature of Funeral Service Lice		Carrol			Serv	9/8/98	Hampst	eaa,	MD
	▶ Brian &	Haigh	tm	HAIGH	HT FUI	NERAL HO				5)
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	notications that ceus	sed the death. Do not	enter the mo	ode of dying	, such as cardiac	or respiratory e	rrest,	100	Approximete Interval Between
	and the same of the same	7								Onset and Deat
	Immediate Cause (Final disease or condition resulting in death)	a KN	EUMONIA							4 DAY:
16			Due to (or as a con	_						
Ē		b. /5c	Henric Her			36			-	20 YRS
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Physician/Me	Part II. Other significant conditions	contributing to death	but not resulting in th	ne underlying	ceuse give	en in Part I.	23b. Dld	tobacco use co	ntributs to	the cause of de
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Completed by									T 041 144	
eted							24e. Wes	en autopsy ermed?	av	ere autopsy findi ailable prior to mpletion of ceus
dr.									of	death?
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000	25. Was case referred to medical exeminer?	Hospital:			Othe	26. Place of Dea				
: To	1 Yes 2 No 27. Menner of Deeth	28a. Dete of It	njury 28b. Tim		28c. Injury Work	4 Li Nursing n		dence 6 □Oth how injury occur		у)
Certification:	1 Natural 5 Pending		Dey Year) Inju	Iry M		k? Yes 2 □ No				
and service of	3 Suicide 6 Could not be determined	288. Place of	Injury - At home, farm etc. (Specify)	, street, fecto	ory, office	- Tal-	28f. Location (City or To	Street and Numt wn, Stete)	per or Rure	al Route Number,
edical C	(Check only 2 Medical Exa	miner: On the basis	st of my knowledge, of examination and/o							
8	one) 29b. Signature and tile of certifier	and rperiptiv	stated.	2	9c. License	number		29d. Date signe	d (Month	Day Vaarl
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Ξ	V CALINE A	MUNDAL	(1)		020	1806		4/8	170	7
Σ	· factor 11	Journal								
2	30. Name appladdress of person who	completed ceuse o	f deeth (Item 23a) (T)	rpe, Print)	4	PD DI	dersbu	- MAX	217	70.1

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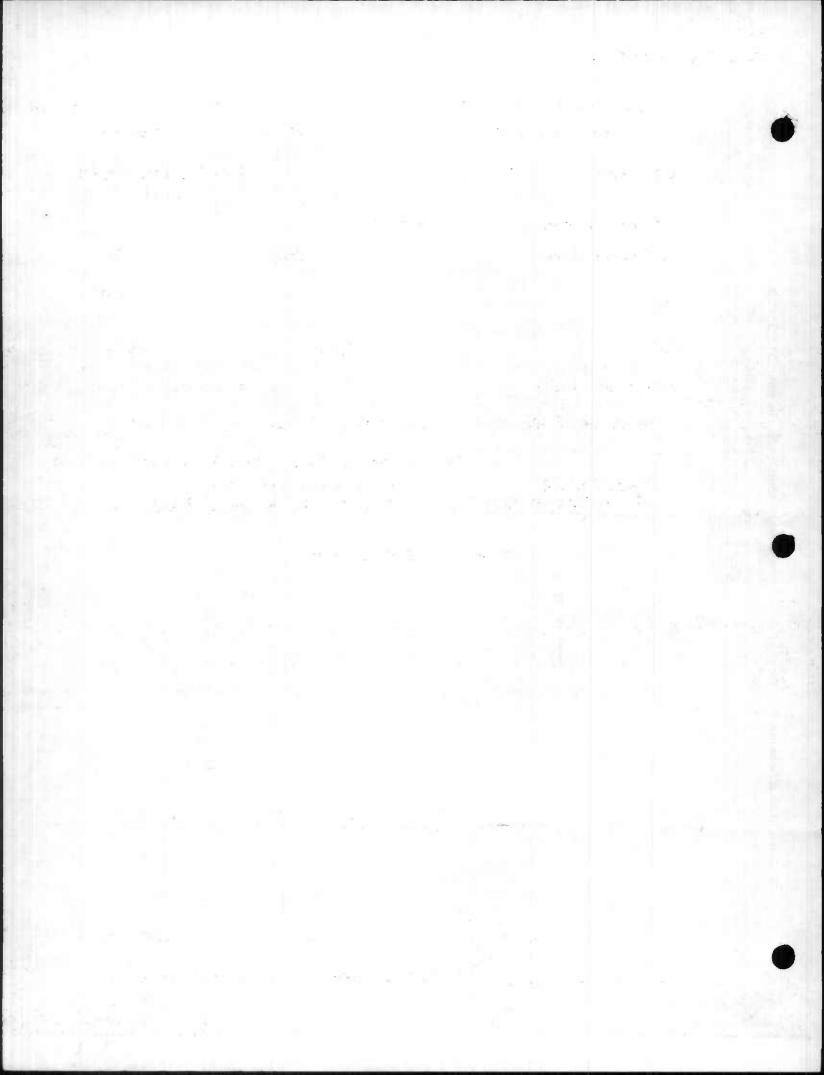
		_	A December 1				(Certific	ate of	Death		Reg. No.	18	29389
-	Physici	an	Decedent's Neme (First								2. Date of D	eeth Day	Year	3. Time of Death
	/Medic		Anna Alic								Septe	-	1998	2005
	Examir	ner	4e. Facility Name (If not in	nstitution, give	street and nu	mber)				4b. City, Town, or	Location of Dee	th 4c. Coun	y of Death	
			Union Hospi	tal of						Elkton		Cecil		
	Funeral		5. Social Sacurity Numba		X ☐ M 2 🔯 F	7. Age (In yrs		Mont	nder 1 Yaar hs Days		8. Dete of B	irth le <i>y</i> , <i>Year)</i>	9. Birthpla Count	lace (State or Foreign try)
- 1	Director		235-26-3461			78	Ψ1	rs.			October	23, 1919	West	Virginia
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ž.	Head	ů	11. Marital Status		Armed Fo		0,5.	If Yes, s	specify Cub	Hispenic Orlgin? (S pan, Mexican, Puerl	pecity Yes or N to Rican, etc.)	0- 14. He	ca - Amarica eck, White, e	
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00	ara E				Year or D	ates:	10. 5	Second State In						
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ž	within 24 hours at To the Funeral D completely filled in	edical	one)	edical Exami	end man	asis of exeminates and states.	etion end/	or investigat	ion, in my	opinion, deeth occu	rrea et the time	date and place	and due to	ine cause(s)
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	1	1	30. Name end eddress of	person who co	mpleted caus	e of deeth (Ite	m 23e) (Tr	ype, Print)				-		
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DHMH 16 Rev 6/95



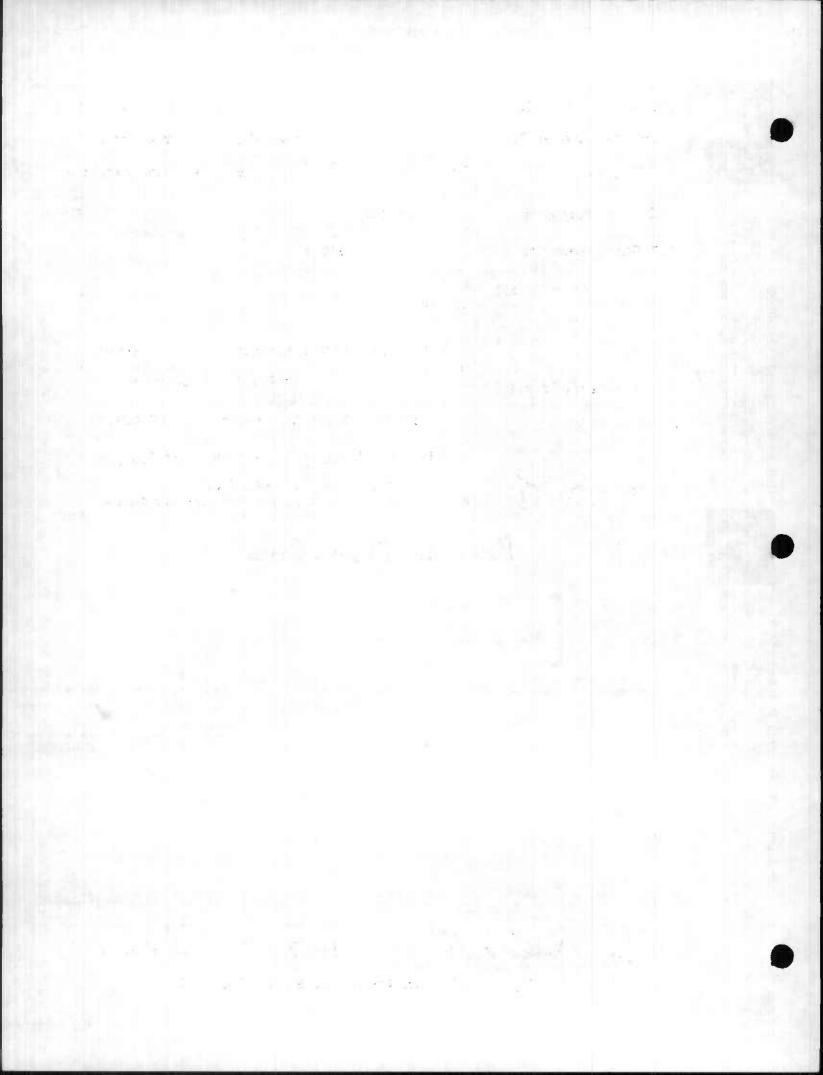
State of Maryland / Department of Health and Mental Hygie	ne	R	20
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BESSIE	REB	BECCA PICKERAL	State of M	/larylar	id / Depa <i>Cer</i>	rtment tificate	of H	lealth and D <i>eath</i>	Mental Hy	giene Reg. No.	29	1390
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the A	ect	Maryland Charle	es		Waldon	10f. Zip (Coda			10g. Citizen of Whef Country?		
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Div To the Hospital or A within 24 hours effer To the Funeral Dire completely filled in b	edical	29a. Cartifliar (Check only one) 29a. Cartifliar (Check only one) 1 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, end dua to fha causa(s) and mannar as stated. XX Medical Examinar: On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.										
To the within 2 To the comple	2	29b. Signature and title of certifier	4961	1				e number M.E		29d. Data signe SEPT	7 ,	Day, Year) 1998
		30. Nama and addrass of person who David Fowler, N		beath (Iter	n 23e) (Type, F 11 Penr	Baltim	ore, Mar	yland 2	L201			
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State of Maryland / Department of Health and Mental Hygiene

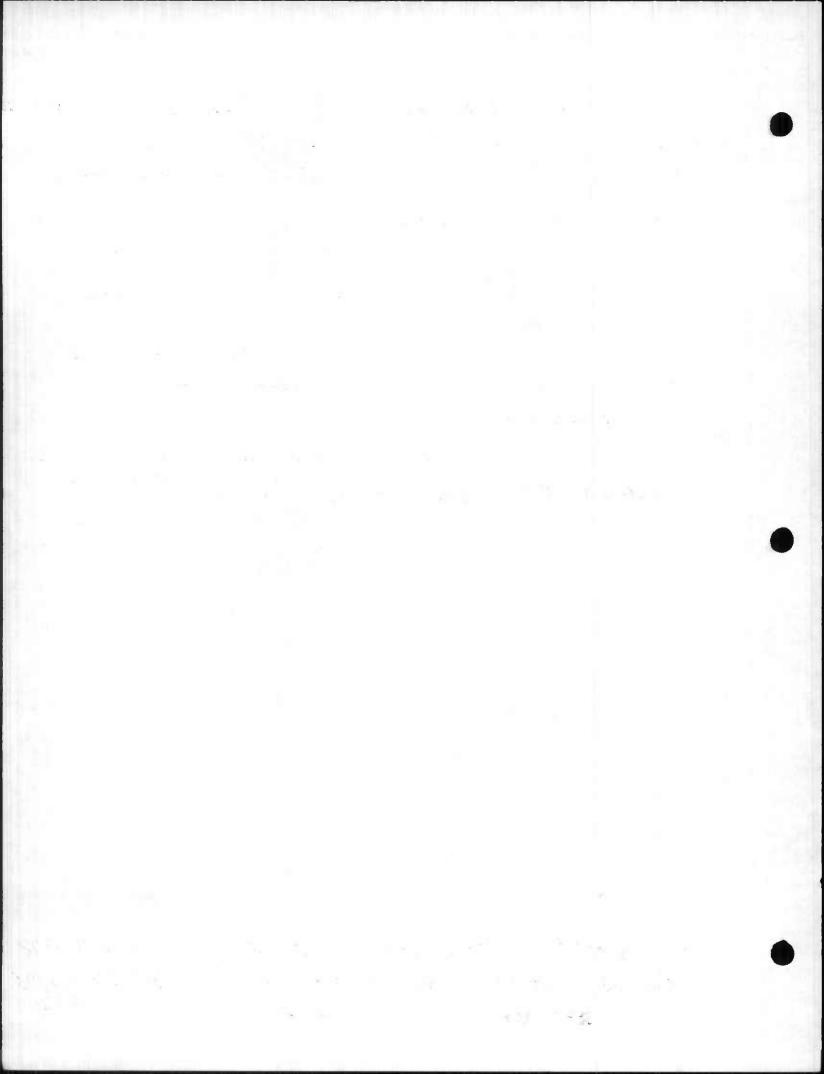
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Morsept. Year Day **Physician** PARK GENE PLANK 9 9 98 6:57 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 307 Blue Heron Ct. Ocean City Worcester 8. Date of Birth (Month, Dey, Year) Oct. 3, 1924 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Months 217-12-1293 73 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD Worcester Yes 2 No Ocean City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 307 Blue Heron Ct. 21842 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Haalth and Mental Hygiene. Important: if item 27 is marked other than "natural, or item any Injury or other traumatic event, the Medical Examina Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married White 1 ☐ Yes 2 ☐XNo Specify: Baltimore, Maryland 21215-0020 Specify: à 3 ☐ Widowed 4 ☐ Divorcad Year or Dates: 1943-46 Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Executive Vice President Banking 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Evelyn Regina Dayhoff Parker Whitefield Plank 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 307 Blue Heron Ct., Ocean City, MD 21842 Helen D. Plank 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Ø Buriel 2 ☐ Cremation 3 ☐ Removal from Stete Cedar Hill Cemetery 9-12-98 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 22. Name end Address of Fecility Huntt Funeral Home, Inc. 21. Signatura DA John P. P. O. Box 156, Waldorf, MD 20604-0156 Khisley M01164 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner that the death certificeta be axecuted ician end burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Lest Due to (or es a consequença of) Box 68760 physician Physician/Medical the Due to (or es e consequence of): 58 USB ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. the signed by the 1 ☐ Yes 2 ☐ No 3 □ Probably 4 □ Unknown Division of Vital Records, by 24b. Were autopsy findings evellable prior to completion of cause of death? 24a. Was an autopsy Completed peeu has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 ■ Residenca 6 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) funeraf 28d. Describe how injury occurred 27. Manner of Death 28b. Time of ne Hospital or Attending P. n. 24 hours after deeth. 28c. Injury at Work? Certification: 1 Natural 5 Pending 2 No Investigation 1 Yes 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical completaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature title of certif 29c. License number ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name as Jean Rinaldo, MD 9714 Healthway Dr. Berlin, MD 21811 31. Date filed (Month, Day, Year) SEP 15 32. Registrar's Signature State 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

						Certific	cate of	Death		Reg. No.			Post
1	Dharaia		1. Decedent's Name (First, Middle, La	ast)					2. Date of D	eath Day	Year	3. Time of	Death
J	Physic /Medi		GEORGE JOS	EPH PERK	INS, S	R.			Septer		1998	11:	18 AM
	Exami		4a. Facility Name (If not institution, gir	ve street end number)				4b. City, Town,	or Location of Dee		of Death		
			Calvert Memor						rederick		vert		
	Funeral Director		5. Social Security Number 6. 215 36 9745 Usual Residence of Decedent	1KIM 2□E	(In yrs. last t		Inder 1 Year onths Days		Ain. (Month, D	irth <i>lay, Year)</i> 8, 1941	9. Birthp Coun Mai	olece (Stete on try) ryland	or Foreign
	how		10a. State 10b. County		10c. City, To	wn or Location	1				1	0d. Inside Ci	
	e Me	cto	Maryland Calver	t	Ches	apeake	Beach					1 🗆 Yes	2 🕅 No
	vith th	Dire	10e. Street and Number			10	f. Zip Code			10g. Citizen of			
	72 hours after death with the Meryland natural', or flems 23a or 28a-f show disal Examines must be notified at	- a	7609 Bayside Roa				20732			United			
5-0020		by Funeral Director	11. Marital Status 1 □ Never Merried 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 No If Yes, Give Year or Detes:			Decedent of F specify Cub		? (Specify Yes or N uerto Rican, etc.)		ce - Americ ick, White, fy: Whit	etc.	
5-0	n 72 hours "natural",	Pte	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	a. Decedent's	Usuel Occup	pation during most of d)	warking	16b. Kind of B	usiness/Inc	dustry	
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and	Mental barked of	Be c	George Leroy Per						rine Eli:		,		
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Balt	permit. Pe Departmen Important: eny injury		21. Signature of Funeral Service Lice		2.				Rausch Fr				
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused tone ceuse on each line	the deeth. Do	not enter the	mode of dyli	ng, such as car	diec or respiratory	errest,		Approximate Interval Bets Onset and D	ween
(09289)	death certificate be executed by a strength of the settlending physician and and for use as the buriel-transit of	/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lssf	· Arterro	nced Due to (or es a Dictor		any.	Arter -LSD ovase	y Direction of Dir	Arrhyt Le Mease		yen	nes.
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	he Hospital or Attending in 24 hours efter death. he Funerel Director: After pletely filled in by the fune	Certification:	27. Menner of Death 1 Naturel 5 Pending 2 Accident investigatio		Year) 28b.	Time of injury	28c. Injur Wor 1 □	yat k? Yes 2□No	28d. Describe	how injury occur	red		
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		Σ	29b. Signeture and title of certifier	0			29c. Licens			29d. Date signe	d (Month, I	Day, Year)	
			Gerald	1'. ster	ner	mj	I	1724	7	Septe	mken	9,10	998
15			30. Name end eddress of person who	completed cause of dec	eth (Item 23a	(Type, Print)			ake Bed	reh Rd	1. a	ungs	r, md.
	Sta Registr		31. Dete filed (Month, Day, Year)	32. Registrer	Signature	5	de	ortal				200	26

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State of Maryland / Department of Health and Mental Hygiene

nysician Medical xaminer neral	DAVID WONEL P Facility Neme (If not institution, gives	st) ALMER	11/14	N (V)		1.04	2. Dete of Dee	th	2	Time of Death
Medical xaminer neral		AI MI-D					Month		reer	3. Time of Deeth
neral	4e Facility Neme (If not institution, giv					- O'r. T	SEPTEME		98	7:20pm
	Washington Adva		+-1				Location of Deeth	4c. County of		
	Washington Adve		la I In yrs. last birthdaj) If Under	1 Year	Takoma P	8. Dete of Birth	Montgo		e (Stete or Foreign
	579-24-9144 Usual Residence of Decedent	X M 2□ F	83 Yrs.	Months	Days	Hours Min.	May 26,		Georg	
14	10a. Stete 10b. County		Oc. City, Town or I	ocation					100	Inside City Limits
unit be notified at rai Director	Maryland Prince G	eorge's	Langley	Park						1 X Yes 2 □ No
Director	10a. Streef end Number 10f. Zip Code 20783							log. Citizen of Wh	et Country?	7
rai		12. Wes Decedent Eve					Dana W. Man an No.	U.S.A.	- American I	Indian
by Funeral	11. Meritel Status 1 Never Merried 2 X Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	er III 0,5.	If Yes, spec		Specify:	Specify Yes or No- to Rican, efc.)	Bleck,	White, etc.	
Completed	15. Decedent's Ed (Specify only highest gra		16a. Dec	edent's Usue a kind of wor	Occupe	etion during most of wo	rking	16b. Kind of Bus	ness/Indust	try
Idm	Eiementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire		se retired	tired)		Privat	0	
S	11th 17. Fether's Neme (First, Middle, Last,			OI CEI		18 Mother's Ne	me (First, Middle,			
Be	John Palmer				-			inalian camamo,		
To	19e. Informent's Neme/Reletionship (Type, Print)	19b. Mai	iling Addrass	(Straet		McIver	r, City or Town, S	tate, Zip Co	oda)
To Be Compl	Addie M. Palmer						ley Park			
	20e. Method of Disposition		20b. Place of Disp cemetery, cr	position (Nan	ne of thar plec	e) Park	Dete	20c. Location - C	ity or Town,	, Stata
once.	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif	Hemoval from Stete	Maryland				09/08 1998	_aurel,	Maryla	and
g	21. Signeture of Funeral Servica Licer	see 1		22. Name en	d Addres	ss of Fecility				
8	Nanca A.	Percente		7474 I	ando	NS FUNE	RAL HOME d, Landov	van Man	bnelv	20785
cian lical iner	23a. Pert1. Enter the disease, or com shock, or heert failure. List only Immedieta Cause (Finel disease or condition rasulting in death)	· Ga	ng ven	ed	the	e l	bowl	1.	Or	R W/S
n/Medical Examine	Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disaase or Injury that initiated events rasulting in death) Lest	c. Myer d.	e tofor as a cons	yer	al	we	disc	ndis		years
/ Physician/	Pert li. Other significant conditions of	ontributing to death but r	not resulting in the	underlying c	ause giv	en in Pert I.	23b. Dld t	obacco use cont	ribute to th	e cause of death
by Ph							101	res ac No	3 Probab	ly 4 ☐ Unknow
Completed b							24e. Wes	en autopsy med?	aveile	autopsy findings ble prior to letion of cause oth?
mo.	Caroline In 1						1 🗆 Y	es 22No	1 🗆 Y	es 2 No
Be	25. Was case referred to medical exeminer?					26. Place of De	eth (Check only o	ne)		
0	1 ☐ Yes 2 No	Hospitel: 1 Inpatient	2 ☐ ER/Outpeti			4 Li Nursing	Home 5 ☐ Resid			
:uo	27. Menner of Deeth 1 △Naturel 5 ☐ Pending	28a. Data of Injury (Month, Dey Y	'ear) 28b. Time Injury		8c. Injun		28d. Describe h	low Injury occurre	d	
Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homlcide Accident investigation Could not be determined Cou				M 1 ☐ Yes 2 ☐ No reet, fectory, office 28f. Location (Street end Number or Rura City or Town, State)			r or Rural R	oute Number,	
edical	29s. Certifier (Check out) Medical Example	ysician: To the best of r niner: On the basis of ex end mannar state	emination and/or	ath occurred investigation,	et fha tin , in my o	na, data and plec plnion, deeth occ	a, end due to the durred et tha tima,	ceuse(s) and man data and place, a	nar as state nd due to the	ed. a ceuse(s)
Medical Cer	29b. Signeture end title of cartifier	A sid maintai state	//	290	c. License	e number		29d. Dete signed	(Month, De	y, Year)
10	- Ilano Ol	rent	1	7)2	8921	5 .			
	O Nome and address of account	and the state of t	h (team Day) (Tr.	Drint\ 1				/-	1-1	998 MD2
	Neme end eddress of person who	completed cause of deel	th (Item 23e) (Type	9, Print)	an-	wa la	Numer	Ces	1 10	MAZ

SEP O PL

ASP

Certific

cate	of Death	Reg. No.	
		2. Date of Death	

Physician	
/Medical	
Examiner	

Directo

Funeral

by

Completed

Angel Humberto Robles Pacheco

Dey SEPTEMBER 05 1998

3. Time of Death 0030 A

4a Facility Name (If not institution, give street end number) 1906 AMHERST RD. APT# 202

4b. City, Town, or Location of Death HYATTSVILLE

4c. County of Death PRINCE **GEORGES**

Funeral Director

7 is marked other than "natural", or itsms 23a or traumatic event, the Medical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours aftar of Department of Health and Mantal Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Madical Examples once.

Physician /Medical

Examiner

physician and s the bunal-trans

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director,

funeral

3

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cartificate

After this

after death. Director: Aft

othe F

Hospital 24 hours Examiner

Physician/Medical

by

Completed

Be

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Certification:

edical

Baltimore, Maryland 21215-0020

the Maryland

death

5. Sociel Security Number unavailable Usuel Residence of Decedent 10a. State 10b. County

1. Decedent's Name (First, Middle, Last)

6. Sex M 2□ F 7. Age (In yrs. lest birthdey) 31 Yrs.

If Under 1 Year 8. Date of Birth (Month, Dey, Year) Hours Min. 2/10/67

 Birthplace (State or Foreign Country) Salvador

10c. City, Town or Location Prince Georges Hyattsville 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number

1900 Amherst Road, #202

College (1-4or 5+)

10f. Zip Code 20783

Days

Months

10g. Citizen of What Country?

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) ¥ Yes 2 No Specify:Salvadoran Race - American Indian, Bleck, White, etc. Specify: Hispanic

Salvador

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

0 17. Father's Name (First, Middle, Last) Construction

Construction

Jose Antonio Pacheco Escobar

18. Mother's Name (First, Middle, Maiden Surname) Reina Elizabeth Robles

9/14/98 EL SALVADOR

19a. Informant's Name/Relationship (Type, Print)

Verbal Carmelo Pacheco 20a. Method of Disposition

1 Burial 2 Cremation 3 Removel from State

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900 Amherst Road, #202 Hyattsville, MD 20783

20b. Placa of Disposition (Name of cemetery, crematory or other place)
FAMILY CEMETERY

9/14/

20c. Location - City or Town, State

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee Ducor 22. Name and Address of Facility
W.H. Bacon Funeral Home,
3447 14th Street, N.W.
Washington, such es cardiac or respiratory arrest,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

Approximete Interval Between Onset and Death

disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

3 Probably 4 Unknown

24a. Was an autopsy performed?

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Sulcide

Investigation

6 Could not be

5 Pending

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

1 Yes

Other: 4 Nursing Home SPResidence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 0020 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

at and Number or Rural Route Number 1906 Am

29a. Certifie consid

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Sign nd title of certifie

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) SEPTEMBER 05, 1998

this of person who completed cause of death (Item 23a) (Type, Print)

Locke

111 Penn Street, Baltimore, Maryland 21201 Registrar's Signature

tha death certificate be Division of Vital Records, or Attending Physician:

Box 68760.

Registrar

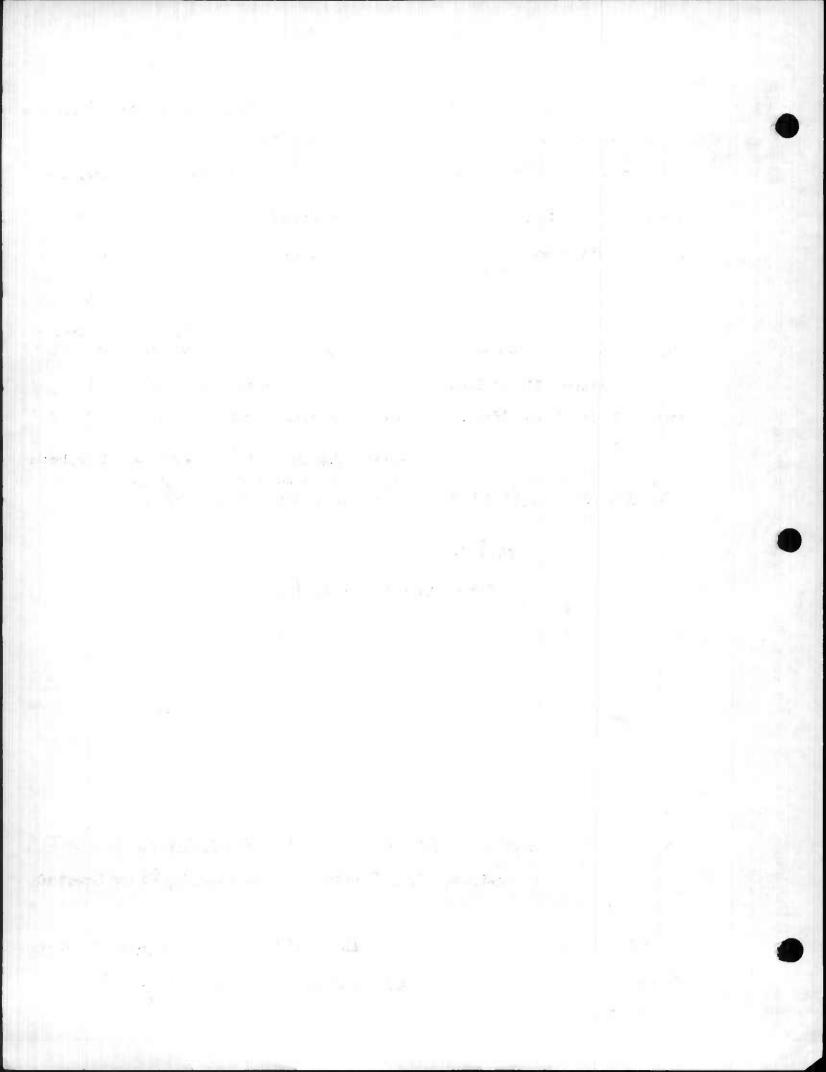
DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Katherine Quinn 4b. City, Town, or Location of Deeth 4c. County of Death 2011 /Medicai 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 605 Bainbridge Road 8. Dete of Birth (Month, Day, Year) Cecil Port Deposit 5. Social Security Number if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funerai** Birthplace (State or Foreign Country) 1 M 2 XF Months Days Hours Yrs. 220-04-0028 31 1967 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ♥ Yes 2 No Maryland Cecil Port Deposit 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? or items 23a or 67 North Main Street 21904 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: A 3 Widowed 4 Divorced White Year or Detes: 'naturel', Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry T.C. Simons, Inc. I Hygiana. Elementary/Secondery (0-12) College (1-4or 5+) Bel Air, Maryland Twelve Years Flagger other permit. Pagas 1 and 2 should be file Dapartmant of Haalth and Mantal Hy Important: If Item 27 is marked oths any Injury or other treumatic avent 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Patrick Elword Quinn Geraldine Brewer 19a. Informent's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Patrick Elword Quinn (father) 67 North Main Street, Port Deposit, Maryland 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State 9/11/98 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Company West Chester, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name end Address of Facility
Lee A. Patterson & Son Funeral Home THERAM Y Perryville, Maryland LOWER 21903-0188 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final trauma diseese or condition resulting in death) **Examiner** Due to (or es e consequence of): Examiner Vehiche cartificata be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): usa as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed pege 2 s cartificata 1 Tyes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifica ataly filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA TN Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 5 Pending Investigation 1 Neturel 2011 PM 1 Yes 2 No 2 Accident 3 Suicide Vehicle Accident 98 Motor 6 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di complataly filled in Raburay Cecil Cousty 605 Baw Bridge RD, Port Depost

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 605 BAWBRIDGE RD, PORT DEPOSIT MD 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D5 1261 SeptemBer 7, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION HOSPITAL, EIKtON MARY IAND Silveeman 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State **SEP 11** 0 Registrar



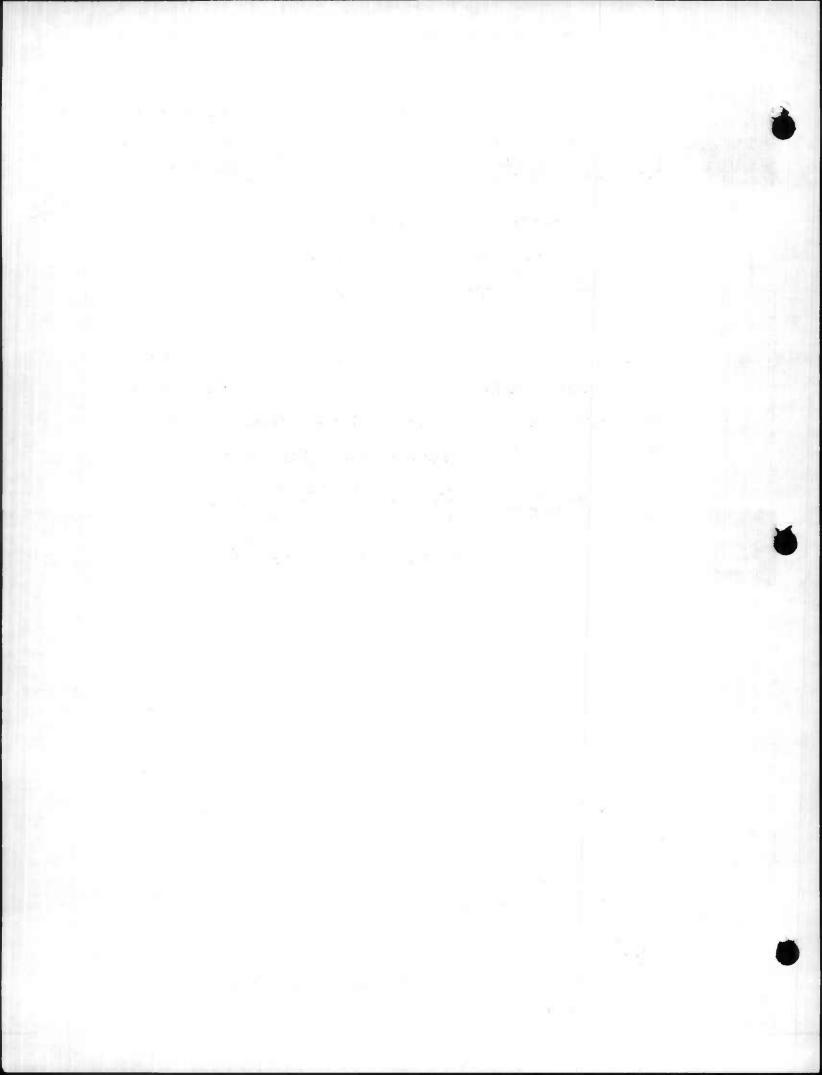
State of Maryland / Department of Health and Mental Hygiene

			,	Certificate of	Death	Reg. No.	29396
		1. Decedent's Name (First, Middle, Last)	<i>m</i>	1		e of Death	3. Time of Death
	Physician	MATTIE	al;	IEEN	Mod	1 7 0 1	1.50 As
	/Medical Examiner	4a Facility Name (If not institution, give street	and number)		tb. City, Town, or Location of	Death 4c. County of Dee	eth
	Examine	PRINCE GEORGES HOS	PITAL CENTER		Cheverly	Prince Ge	anrae's
	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last b	pirthday) If Under 1 Year	If Under 24 Hrs. 8, Det		inthplace (State or Foreign country)
ם	Director	579-76-9406 1□ M 2 Usual Residence of Decedent	93	Yrs. Months Days	Hours Min. (Mo	nth, Day, Year) C y 22, 1905 Ann	e Arundel, MD
leryland	show of	10a. State 10b. County		wn or Location		PA ST	10d. Inside City Limits to Styles 2 □ No
5 5	or 28e-f e	Maryland Prince Geor	ge's La	andover			
h with		6978 Hawthorne Stree	t	10f. Zip Code 2078	35	United Sta	
5-0020 72 hours efter death with the Meryland	other than "natural", or thems 23s vent, the Medical Examinar must be Completed by Funeral	1 Never Married 2 Married 1 Nover Married 1 Nover Married 2 Married 1 Nover Ma	as Decedent Ever in U,S. med Forces? Yes 2 No Yes, Give par or Dates:	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☒ No	lispanic Origin? (Specify Ye an, Mexican, Puerto Rican, e Specify:	Specify:	
9 2	Part Part	15. Decedent's Education		a. Decedent's Usual Occup	ation	16b. Kind of Business	
T. 5	or than "natural, for the leader.	(Specify only highest grade com		(Give kind of work done life. DO NOT use retired	during most of working d)		
2121 d within	Comp	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)	Housewife		Private	
D =	Set O	17. Father's Name (First, Middle, Last)			18. Mother's Name (First,	Middle, Maiden Surname)	
ylan ould be	To Be	Elliott Toogood			Mary Brad	lford	
Maryland	le marked eumatic e	19a. Informant's Name/Relationship (Type, Pr	int) 10	The Mailing Address (Street		Number, City or Town, State,	Zin Code)
Ma	Tie m Treum					Hill, Marylan	
0	Rem 27 other tr	Gladys Washington - D		of Disposition (Name of	Date		
O = 2	5 = 0	1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove	comot	tery, crematory or other place	>9)		
thr	E E	4 Donation 5 Other (Specify)	Harmo	ony Memorial Par	$k = \frac{9}{15}$	98 Landover,	Maryland
Baltimo	Important: If eny lolly or poce.	21. Signature of Euneral Service Licensee	not TIT		NERAL HOME, I	Inc. .,Washington,	D. C.
		23a Part Enter the disease, or complication or heart failure. List only one cau	s that caused the death. Do	1	-		Approximate Interval Between
Phy	ysician	Contest of heart favore. List only one cau					Onset and Death
/ /N	ledical aminer	Immediate Cause (Final disease or condition resulting in death) a		2 SHO			1
2	iner		STAPHA	LOCCAL	- SEPT	ICIMIA	
68760, ifficete be execute	physician and the burletransit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	SFUERE	E HVPO	TENSID	N	
68760,	physician the bu	Cause (Disease or injury that initiated events	Due to (or as a	consequence of):	12 -10		
	00 2	resulting in death) Last	+CUTE		-TUBULI	OR NEROS	10
Box	for use	0					
0.0	o o o	Part ff. Other significant conditions contribution	ng to death but not resulting	in the underlying cause giv	ren in Pert I. 23	b. Did tobacco use contribut	ts to the cause of death?
P.O.	igned by the strandin be detected for use by Physician/N	DEEPVIEN	V THROM	u Busis t	FLETT	1 Yes 2 No 3 1	Probably 4 Unknown
I Records, P.O. Box The law requires that the death cer	should should	LEG, Z		RCANSUS		a. Wes en eutopsy performed?	. Were autopsy findings available prior to completion of cause of death?
	. page 2	FAILURE A	CUTE INT.			1 Yes 20140	1 ☐ Yes 2 ☐ No
Vital	director, pag	25. Was case referred to medical axaminer?	1.		26. Place of Death (Chec		
- >	1 0 P	1 ☐ Yes 2⊠ No Hospita	1 to Inpetient 2 LERVC			☐ Residence 6 ☐ Other (Sp	ecity)
Division of Vita	el Director: Affert led in by the funent Certification:	. 9	. Date of Injury (Month, Day Year) 28b.	. Time of 28c. Injury Wor	y at k? Yes 2 □ No	scribe how injury occurred	
S de la constant	ic a	3 Suicide 6 Could not be	Diese of laine. At home			eation (Street and Number or I	Qurel Poute Number
N A	in by	4 ☐ Homicide determined 200	 Place of Injury - At home, building, etc. (Specify) 	term, street, tectory, ornos		or Town, State)	nural riodie Number,
1 2	O O						
Hoep 24 No	To the Funeral Director: After the completely illed in by the funeral Medical Certification:	(Check only 2 Medical Examiner: O				to the cause(s) end manner of e time, date and place, and do	
th of the	Me Me	29b. Signature end title of certifier	~ 1 ^	29c. Licens	e number	29d. Date signed (Mor	nth, Day, Year)
F 3	6 + 3	1 5 K. M	DHPI	10.	2/200	Sept- 7	
	7)	30. Name and address of person who complete	ed cause of death (from 23a	(Type, Print)			
1	5/		A	BHANDUE	R PARKUA	Y, GREENBE	elTMD 20776
	State Registrar	SEP 0 9 1998	22. Registrar's Signature	low vi			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 7

PRIVEIR		1. Decedent's Nar	me (First, Middle, La	st)				DC III II II	2. Date of De Month		3. Time of D
Physici /Medi			ELIZABI	ETH IO	NA	RITTE	R		Septem	Day Der 11 19	998 2:3
Examir		4e. Facility Name	(If not institution, giv	re street and numbe	r)			4b. City, Town, o	r Location of Deat		
			2115 Pc	owley Rd.				Winga	te	Dorch	hester
Funeral Director		5. Sociel Security 214-18 Usual Residence	8-4044	I Administration	nge (In yrs. 92	last birthdey) Yrs.	H Under 1 1 Months E		8. Date of Bir (Month, Da March	1 906 r	9. Birthplece (State or F Country) Maryland
show M m		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City
E 2	to	MD	Dorche	ester		Wind	gate				1 ☐ Yes 2
or 28a-f	Je l	10e. Street and No	umber		_ (10f. Zip Co	ode		10g. Citizen of W	/hat Country?
23a c	a D		2115	Powley Ro	d.		21	675		U.S.A.	•
si', or items	by Funeral Director		rried 3 Married	12. Was Deceder Armed Forces 1 Yes If Yes, Give Year or Dates	No No		Wes Deceden	t of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)	14. Rece Black Specify:	e-American Indien, k, White, etc.
Beal	Completed	(Sne	15. Decedent's En	ducation		16a. Deced	dent's Usual C	occupetion fone during most of w	orkina	16b. Kind of Bus	siness/Industry
. Wag	npie	Elementary/Sec		Coilege (1-4o	r 5+)	life.	DO NOT use i	retired)	UIKING		
al Hygiane. I other ther vent, I're N	Co	10					homema	aker		own ho	ome
od other	Be	17. Father's Name	(First, Middle, Last,					18. Mother's No	eme (First, Middle	Meiden Sumame	9)
marked c	2		Thomas	Risdon	Po	wley			Archie		nes
g w 8			Name/Relationship (-	treet and Number or I			State, Zip Code)
m 27 her t			Ritter -	nusband	0.01		Powley		gate, MD		
onto yor		4 Donation	Cremetion 3 5 Other (Specif	y)			natory or othe Er Memo	or _{rplace)} orial Park	9/14		city or Town, State ge, Maryland
Departmer important: any injury once.		1 oke	the disease or com	Thom	In and the goal	T1 70	nomas E 00 Locu	Address of Facility Funeral Hor ust St. Car f dying, such es cardi	mbridge M		Approximate Interval Betwe
ysician Medical aminer		Immediate Cause disease or conditi resulting in death)	(Finel		nd-s			kinson		^	Onset end De
aminer	2				Due to (o	r as a consec	luenca of):	ICINSUP	2 12/26	450	years
clan and	I Examir	Sequentially list of any, leading to incause. Enter Und	onditions, mmediate derlying or injury	b		r as a conseq	quenca of):	yencsop _j	3 13/3 (<i>u</i> 3 <i>E</i>	gears
nding physician and use as the buriel-transit	n/Medical Examiner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease othat Initiated event resulting in death)	IS T	b c	Due to (o	r as a consec	uenca of):	JEWSOF)	3 13/30		gears
	ician/Medical Examir	resulting in death)	Last		Due to (or	r as a conseq	quence of): uence of):				0
by the ettendin ached for use	Physician/	resulting in death)	IS T		Due to (or	r as a conseq	quence of): uence of):		23b. Did	tobacco use con	tribute to the estuse of a
s been signed by the ettendin 2 should be detached for use	by Physician/	resulting in death)	Last		Due to (or	r as a conseq	quence of): uence of):		29b. Did 1 □	tobacco use con	tribute to the escuse of
s been signed by the ettendin 2 should be detached for use	Physician/	resulting in death)	Last		Due to (or	r as a conseq	quence of): uence of):		29b. Did 1 □	an autopsy	tribute to the eduse of a 3 Probably 4 Un
s been signed by the ettendin 2 should be detached for use	Be Completed by Physician/	resulting in death)	is Last	ontributing to death	Due to (or	r as a conseq	quence of): uence of):	e given in Part I. 26. Place of D	23b. Did 1 □ 24a. Was perfo	an autopsy	tribute to the escuse of a 3 Probably 4 Un aveilable prior to completion of cau of deeth?
centificata has been signed by the ettendin rector, page 2 should be detached for use	To Be Completed by Physician/	Part II. Other algni	ificant conditions of	ontributing to death	Due to (or but not resulting the contract of t	r as a consequence of as e consequence of the unitary in the unita	uence of): uence of): uence of): nderlying caus	e given in Part I. 26. Place of Doubles: 4 □ Nursing	23b. Did 1 □ 24a. Was perfo	an autopsymed? Yes 2 No	tribute to the eduse of of 3 Probably 4 Un 24b. Were eutopsy find aveilable prior to completion of cau of deeth? 1 Yes 2 No
this certificate has been signed by the ettendin al director, page 2 should be detached for use	To Be Completed by Physician/	Part II. Other algni 25. Was case refe	ificant conditions control to medical	ontributing to death Hospital: 1 □ Inpat 28e. Dete of In	Due to (or but not resulting the contract of t	r as a conseq	uence of): uence of): uence of): uence of): at 3□ DOA 28c.	26. Place of Do Other: 4□ Nursing injury et Work?	23b. Did 1 □ 24a. Was perfo	an autopsy med?	tribute to the eduse of of 3 Probably 4 Un 24b. Were eutopsy find aveilable prior to completion of cau of deeth? 1 Yes 2 No
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician /Medical Examiner

Funeral Director

28a-f show the Medical Examiner must be notified 6 Items 23a death filed within 72 hours after natural', or

Hygiene. . Peges 1 end 2 should be fil ment of Health end Mental H fant: If item 27 is marked oth jury or other traumetic even permit. Pege Department of Important: If any injury or once.

Saltimore, Maryland 21215-0020

Physician /Medical Examiner

physician s the buria

Box 68760 attending p P.O. signed I Records, page 2 s certificate Vital of this Hospital or Attending Pt
 24 hours effer death.
 Funeral Director: After the letely filled in by the funeral To the Hospital or within 24 hours eft To the Funeral DI completely filled in

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remolds,

1. Decedent's Name (First Middle Last) 2. Date of Death Worrell Lee Reynolds, Sr. September
4b. City, Town, or Location of Death 4c 4a. Facility Name (If not institution, give street and numbar) 4c. County of Death Union Hospital of Cecil County Cecil Elkton | H Under 1 Yaar | H Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | March 20,1936 5. Social Sacurity Number 6. Sex 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 1 € M 2 □ F 212-32-4601 Vrs 62 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Director Cecil Maryland Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 White Oak Drive 21903 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1. IŽYyes 2 □ No If Yes, Give Year or Detes: 1955 → 1958 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Nevar Married 2 Namled 1 Yes 2 X No Specify: À 3 Widowed 4 Divorced White Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Self-Employed Truck Driver 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Malden Surnama) Be Warrell Reynolds Esther Cosner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Patricia S. Reynolds (wife) 11 White Oak Drive, Perryville, Maryland 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) North East Methodist Cemetery 9/9/98 | North East, Maryland 21. Signature of Funeral Service License 22. Nama and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188 terson, Momenta 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Finel disease or condition rasulting in death) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated events resulting In deeth) Last Physician/Medical Due to (or as a consequança of): Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown g 24b. Ware autopsy findings available prior to completion of causa of deeth? Completed 24a. Was an autopsy 1 Yes 2 No t□Yes 2□ No. 25. Was case referred to m Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 8 Other (Specify) To 1 Yes 2 No Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 3 Suiclde 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Eartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted. Medical dfcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tith of 29c. License number 29d. Data signed (Month, Day, Year) D21578 September 4, 1998 plated cause of death (Item 23a) (Type, Print) 30. Name and address of person Satoshi Ikeda, M.D., 2300 Pennsylvania Ave., Suite 3D, Wilmington, DE

State

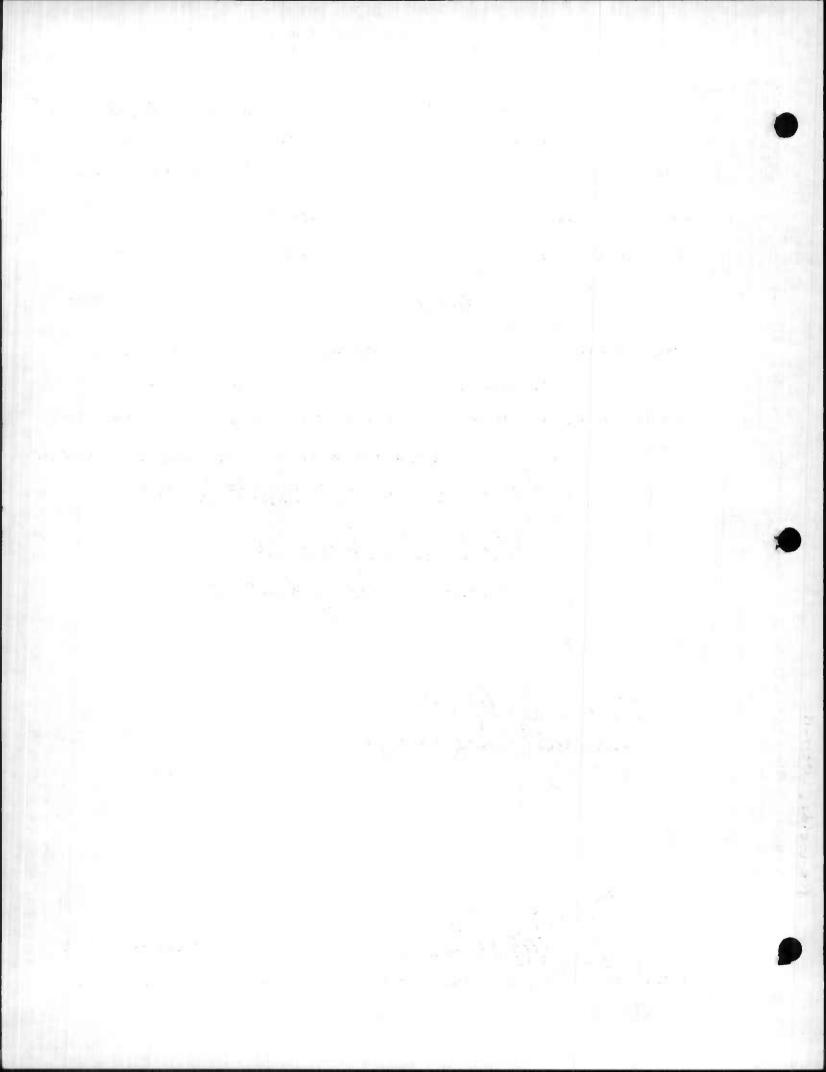
Registrar

31. Dete filed (Month, Day, Year)

SEP 0 9 1998

3

Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** September 3, 1998 Yolanda B. Rogers 1:30 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 2, 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Yrs. 412-30-1515 Tennessee Director Usual Residence of Decedant the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location ortant: If Item 27 is marked other than "natural", or Items 23a or 23a-4 show injury or other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Harwood 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter death with nent of Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or Items 23a or: 20776 USA 387 Polling House Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) (unknown) Alfonse Salomone Mary 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) John W. Rogers, Sr./Husband 387 Polling House Road Harwood, Maryland 20776 altimore, 20b. Place of Disposition (Name of cematary, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any Injury or Lakemont Mem'1. Gardens 9-5-98 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final diseasa or condition resulting in death) /Medical 3 years Examiner Dua to (or as a consaquance of) Examiner 40515 that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of); Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last lena P.O. Box 68760, Anusia Physician/Medical Due to (or as a consequence of): 88 esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown disease 1 ☐ Yas 2 ☐ No signed t Division of Vital Records, þ 24b. Were autopsy findings available prior to 24e. Was an eutopsy performed? Completed completion of ceuse of death? page 2 s certificate has 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese referred to medicel examiner? director, Be 28. Place of Death (Check only ona) 1 | Yes (25€No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1991-Inpatient 2□ ER/Outpatient 3□ DOA 10 After this funeral 27. Mannar of Daath 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 Yas 2 No 24 hours after death.

Funeral Director: A investigation 2 Accidant 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, atc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and member as season.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D005327 128 30. Name and address of person wifo completed ceuse of death (Itam 23a) (Type, Print) M& 21403 Peter Stengel, M.D. rank

State Registrar

0 8 1998

31. Date filed (Month, Dey, Year)

32. Registrar's Signatura

						it of Health and e of Death		Reg. No.	E(e	
Physicia	an	1. Decedent's Neme (First, Middle, Las					2. Dete of D	eeth Dey	Yeer	3. Time of Death
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Examin Funeral	er	4s. Fecility Neme (If not institution, give 1365 W . Ja.: 5. Sociel Security Number 6. S	rrettsvi	(In yrs. lest birthde		COOP			Hari	ford Diece (State or Foreitry)
Director		237-60-3983 Usuel Residence of Decedent	DM ZNF	58 Yrs.			2/19/	1940	N. (Carolina
A N		10e. Stete 10b. County		10c. City, Town or	Location				1	0d. Inside City Limi
The	to	Md. His	rford			Forest 1	Hill			1 □ Yes 2 📉
or 28	lrec	10e. Street end Number			10f. Zip			10g. Citizen of V	Vhat Cour	ntry?
23a c	al D	1365 W. Jarr	ettsvill	e Road		21050		U.	S.A	•
al', or items 23a or 28a-f show Examiner must be notified at	by Funeral Director	11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No. If Yes, Give Yeer or Detes:		Was Deced If Yes, spec	dent of Hispanic Origin? cify Cuban, Mexican, Pu 2 No Specify:	(Specify Yes or Nerto Rican, etc.)	o- 14. Reco	k, White,	en Indlen, etc.
natural',	ted	15. Decedent's Ed	ucation	16a. Dec	edent's Usu	el Occupation	20150	16b. Kind of Bu		
reportant: If lem 27 is marked other than "n any injury or other treumatic event, the Med ones.	Completed	(Specify only highest gre Elementery/Secondery (0-12)	College (1-4or 5-	life	DO NOT us	rk done during most of vise retired)	vorking	Н	ome	
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Department of I important: If the any injury or of once.		1 Burial 2 Cremetion 3 4 Donetlon 5 Other (Specify		cametery, ci	remetory or o	ther plece)	974			
injur.	1	21. Signeture of Funeral Sentice Licen				emation Id Address of Fecility	1998	nampst	eaa,	Maryla
any ir		23a. Pert1. Enter the disease, or compshock, or heart feilure. List only	en Kery	77	E. Ja	. G. Kurt	lle, Ma	ryland	al H	ome, P.
ysician Medical aminer	Examiner	Immediate Cause (Final disease or condition resulting in death)	BONE	PST C Due to (or es e cons E MET Due to (or es e cons	equence of):					Intervel Between Onset end Deeth
		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury	LUNG		TAST	ASIS				2 month
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the ett hed fo	sicia	Pert II. Other significant conditions co	entributing to death but	not resulting in the	underlying c	ause given in Pert I.	23b. Dld	tobacco use cor	tribute to	the cause of deat
p eq	by Phy	CACHEXIA				_ 1□	Yss 2□ No	3 ☐ Prol	bebly 4 Unkno	
hes been si ge 2 should	Completed							s en eutopsy omed?	80	ere eutopsy findings elleble prior to mpletion of cause desth?
page he	S						10	Yes 2 No	10	Yes 2□ No
	Be	25. Wes case referred to medical examiner?	Hospital:				eeth (Check only	one)		
0 D	on: To	27. Menner of Deeth 1 Neturel 5 Pending	Hospitel: 1 Inpatien 28e. Dete of Injury (Month, Day		of 2	Other: 4 Nursing 18c. Injury at Work? 1 Yes 2 No		Home 5 Residence 8 Other (y)
To the Funeral Director: After the completely filled in by the funeral	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be 4 Homicide determined	28e. Pleca of Injur building, etc.	y - At home, farm, : (Specify)			281. Location City or To	(Street and Numb wn, Stete)	er or Rura	al Route Number,
To the Funeral	edicai	29e. Certifier (Check only one)	reician: To the best of Iner: On the basis of e end menner stete	xaminetion end/or	ath occurred Investigetion,	et the time, date and pla In my opinion, deeth oc	ce, and due to the curred et the time	cause(s) and ms	nner as si and due to	teted. the cause(s)
To th comp	Me	29b. Signeture and title of certifier	P	19.	290	D 3185	6	29d. Dete signed 09/03/	(Month,	Day, Year)
1		30. Name end eddress of person who of DESH SLARM	ompleted cause of dec	18 14 /8	e, Print) EL AI	D 3185	USTON	mo g	104	-7
Stat Registra		31. Dete filed (Month, Day, Year) SEP 1 0 1998	32 Registrer		Spo	rela!				

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 1130 AM BRANDY MICHELLE REDMAN /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 24 Hrs. 8. Data of B TRAUMA CENTER If Under 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Months Days Hours 1 M 2 F 212-17-87 Yrs. Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f ahow The Madical Examiner must be notified at 1 TYAS 2KINO Director Maryland Harford Bel Air 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 21015 USA 1444 Fountain Glen Drive Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. after Nevar Married 2 Married 21215-0020 White 1 Yas 2 No Specify: Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) permit. Peges 1 and 2 should be filed with Department of Health and Mental Physient Important: if item 27 is marked other that any Injury or other traumatic event, that page. Student High School 11 Baltimore, Maryland 17. Fathar's Nema (First, Middla, Last) 1B. Mothar's Nama (First, Middle, Maiden Surnama) Be Sander Jean Susan Danny Lee Redman 19a Informant's Name/Relationship (Type Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1444 Fountain Glen Drive, Bel Air, MD 21015 Susan J. Redman/ Mother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20e. Mathod of Disposition Data 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gardens 9-12-98 Bel Air, Maryland 21. Signeture of Exmeral Sarvice Licensee 22. Nama and Addrass of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final CEREBRAL disaasa or condition rasulting in death) Examiner Examiner CLOSED that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINE and Sequentially list conditions, if any, laading to immadieta cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Box 68760, physician Physician/Medical the Due to (or as a consequence of for use as P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 2 X No 1 Yes 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? a No 1 Yas certificate Division of Vital or Attending Physician: Be 25. Was casa refarred to medical 26. Placa of Death (Check only ona) exeminer? 1⊠ Yas 2□ No Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Hospital: 10 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After Inver inouto 358 5 Panding investigation 1 Netural death. 9-6-98 1 Yas 2 No 2 Accident accident within 24 hours after deat To the Funerel Director: completely filled in by the 3 ☐ Suicida 6 Could not be determined 28f. Location (Stre 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) (Street and Number or Rural Route Number, Town, State) 4 Homicide STREET 1000 Hospital Certifying Physician: To the best of my knowledge, duath occurred at tha time, data and place, and dua to the cause(s) and mennar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the F within 2 To the F assistant Professor 29c. License number 29d. Data signed (Month, Day, Year) Critica 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Shock. Trauma

DHMH 16 Rev 6/95

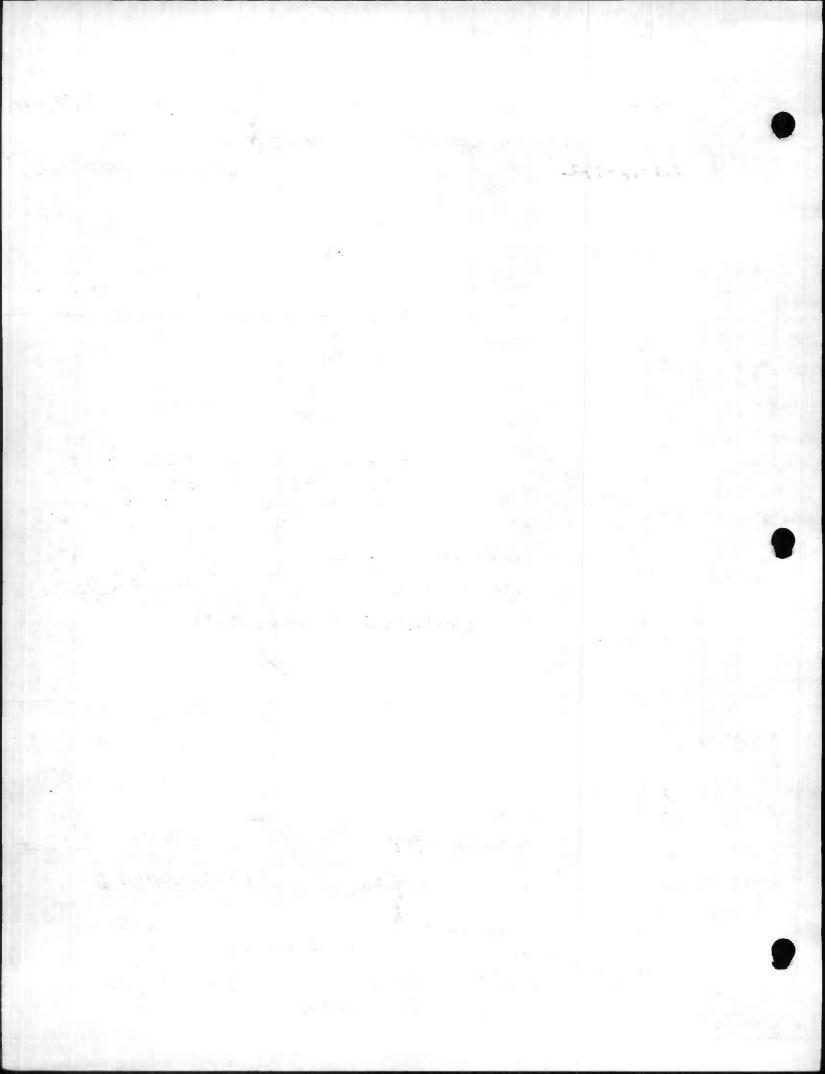
State

Registrar

31. Date filed (Month, Day, Year)

9SEPP1 1 1998

32. Registrer's Signatura



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death SEPTEMBER 3. Tima of Death Arthur Eugene Rhodes Month **Physician** 7:100 arthur Rhodes 11 /Medical 4a Facility Name (If not institution, give street end number) 4b. Cify. Town, or Location of Death 4c. County of Death Examiner BOITIMOR UA MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Bothware City Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1⊠M 2□F Yrs Director Maryland 218-30-2524 Usual Rasidenca of Decedant November 17,1934 the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show 1 ☐ Yes 2 ☑ No Directo Maryland Charles LaPlata 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? with 1 r than "naturel", or itema 23a or the Medical Examiner must be death , Funeral U.S.A. 14. Race - Amarican Indian, Black, White, etc. 6970 Hawthorne Road 20646 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examples. 1 X Yas 2 No 1959 If Yas, Giva Yaar or Dates: _1965 1 ☐ Nevar Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced -1965Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Spacify only highast grade complated) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) Collaga (1-4or 5+) 8th Self Employed Store Owner 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be Helen Patricia Lomay Rhodes 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Wife Same as #10 Helmi Rhodes 20b. Placa of Disposition (Name of cematary, crametory or other place) September 17, 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Maryland Veterans Cemetery | Cheltenham, Marylah 21. Signatura of Funaral Service Licensaa 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 M00668 4270 Hawthorne Rd., Indian Head, Md. 20640

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast,
Shock, or heart failure. List only one cause on each lina.

Md. 20640

Approximate
Intarval Between
Onset and Death **Physician** Immediate Causa (Finel diseese or condition rasulting in daath) /Medical a. Idiopathic pulmosery fibrosis
Dua to (or as a consaquance of): UKKlank Examiner Examiner physician end s the burial-trens Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Ceusa (Diseese or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 883 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other stanificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records. þ 24b. Wara autopsy findings availabla prior to completion of cause of daath? 24a. Was an autopsy performad? Completed certificate has b lirector, page 2 s 1□ Yas 2□No 25. Was casa raterrad to medical Be 26. Plece of Daeth (Check only ona) To 1 Yes 2 No Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) uneral 27. Manner of Daath 1 2 Natural 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 5 Panding invastigation 1 Tes 2 No 24 hours after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of tnjury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 Homicide 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, deta and place, and dua to the ceuse(s) end menner as stated. Wedical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) SKC MO. P11747

State Registrar

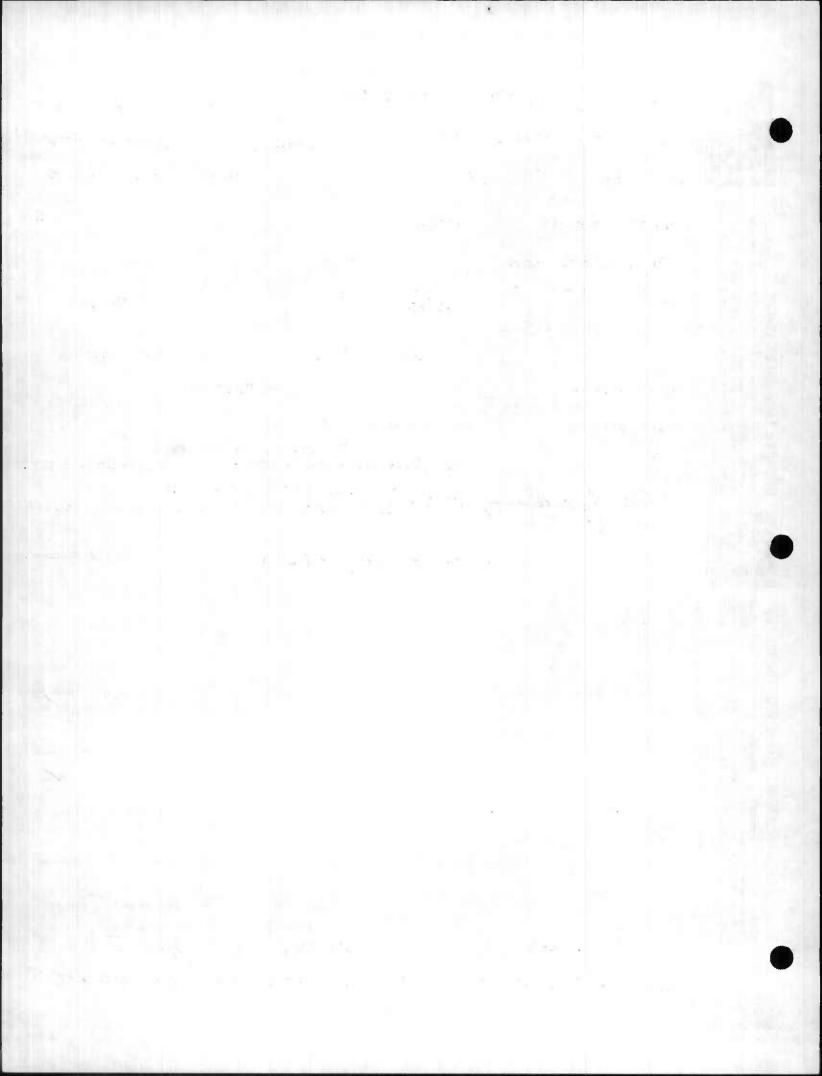
SEP 15

31. Data filed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

ROYNARO Cross ND 2729 St Poul St. Unit Z Boltimore MD ZIZIS ROYNARD Cross NO 32. Registrar's Signature

1998



LEONARD CHARLES RENDER State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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-	2	11	U	U

Physician
/Medical
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1. Decadant's Nama (First, Middla, Last)

2. Data of Death

3. Tima of Death SEPTEMBER 14 1998 5:45

CHARLES LEONARD 4a Facility Nama (If not institution, give street end number)

1X M 2DF

4b. City, Town, or Location of Deeth

MCKENDREE ROAD 5. Social Sacurity Number

Brandywine If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year)

4c. County of Death PRINCE **GEORGES**

Funeral Director

"natural", or items 23s or 28s-f show

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 77 is marked other than "natural", or ther any injury or other traumetic event, the Medical Examina-

Physician /Medical

Examiner

physicien and s the burial-transit

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signed by the e

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this funeral

in 24 hou.

To the Hosp within 24 hos To the Fune completely fi

director.

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Completed

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Certification:

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The law requires that the death certificate be executed

Attending Physician:

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death.

Division of Vital Records, P.O. Box 68760.

Baltimore,

Directo

Funerai

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Usual Rasidance of Dacedani 10a. Stata 10h Count Maryland Charles

10c. City, Town or Location

Yrs.

7. Aga (In yrs. last birthday)

35

Aug. 19, 1963 Arkansas 10d. Inside City Limits

10g. Citizan of What Country?

USA

10e. Street and Number

084-56-4399

Waldorf 10f. Zip Code

Months

1 Yas 2 No

Birthplaca (Stata or Foreign Country)

2227 Hope Circle

11. Maritel Status

20601 Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.)

14. Race - Amarican Indian Black, White, etc. Specify: White

1 Navar Married 2X XMarried 3 ☐ Widowad 4 ☐ Divorced

12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Yeer or Datas:

1 ☐ Yas 2 X No Specify:

16b. Kind of Business/Industry

15. Decedant's Education (Specify only highest grada complated) Elementary/Sacondary (0-12)

Collaga (1-4or 5+)

16a. Decedant's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use ratired) Maintenance

Days

Paving Company

17. Fathar's Neme (First, Middle, Last)

Leland Redner

Betty Tebo

19e. Informant's Name/Ralationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)

18. Mothar's Nama (First, Middla, Maiden Sumame)

Amelia R. Redner - Wife

2227 Hope Circle, Waldorf, MD 20601 20b. Place of Disposition (Nama of cematary, cramatory or other place)

20c. Location - City or Town, Stata

2 Cremation 3 Ramoval from State 4 □ Do 5 Other (Specify)

Trinity Memorial Gardens 9-18-98 Waldorf, MD

23e. Pentl. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Mark

22. Name and Addrass of Facility Huntt Funeral Home, Inc.

Immediata Causa (Final

disaase or condition resulting in death) Examine

Dua to (or as a consequence of):

Dua to (or as e consaquance of)

Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaasa or Injury Physician/Medical that initiated avants rasulting in death) Last

Part II. Other aignificant conditions contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of death?

1 Yes

20 No 3 Probably 4 Unknown

24a. Was an autopsy

26. Place of Daath (Check only ona)

111 Penn Street, Baltimore, Maryland 21201

24b. Wara autopsy findings available prior to completion of cause of deeth?

Approximata Intarval Batween Onsat end Daath

2 No

2 No

25. Was casa rafarred to medical 1X Was 2□ No

27. Mannar of Death

1 Natural

2 Accidant 3 ☐ Suicida

4 Homicide

198

1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 28b. Tima of

Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)

28c. Injury et Work? Yas 2□No

Othar: 4 Nursing Home 5 Residance 6 Nothar (Specify) SCENE 28d. Dascribe how Injury occurred

truck mycot briver in Truck 28f. Location (Street and Number or City or Town, Stata) Rural Routa Numbe

29a. Certifie one)

RTE, 301 4 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signin

29c. Licensa number O.C.M.E

29d. Data signed (Month, Dey, Year) 14,1998 SEPTEMBER

30. Name and eddrass of person who complated cause of deeth (Item 23a) (Type, Print)

Hospital:

28a

LARON Locks 31. Data filad (Month, Day, Yaar)

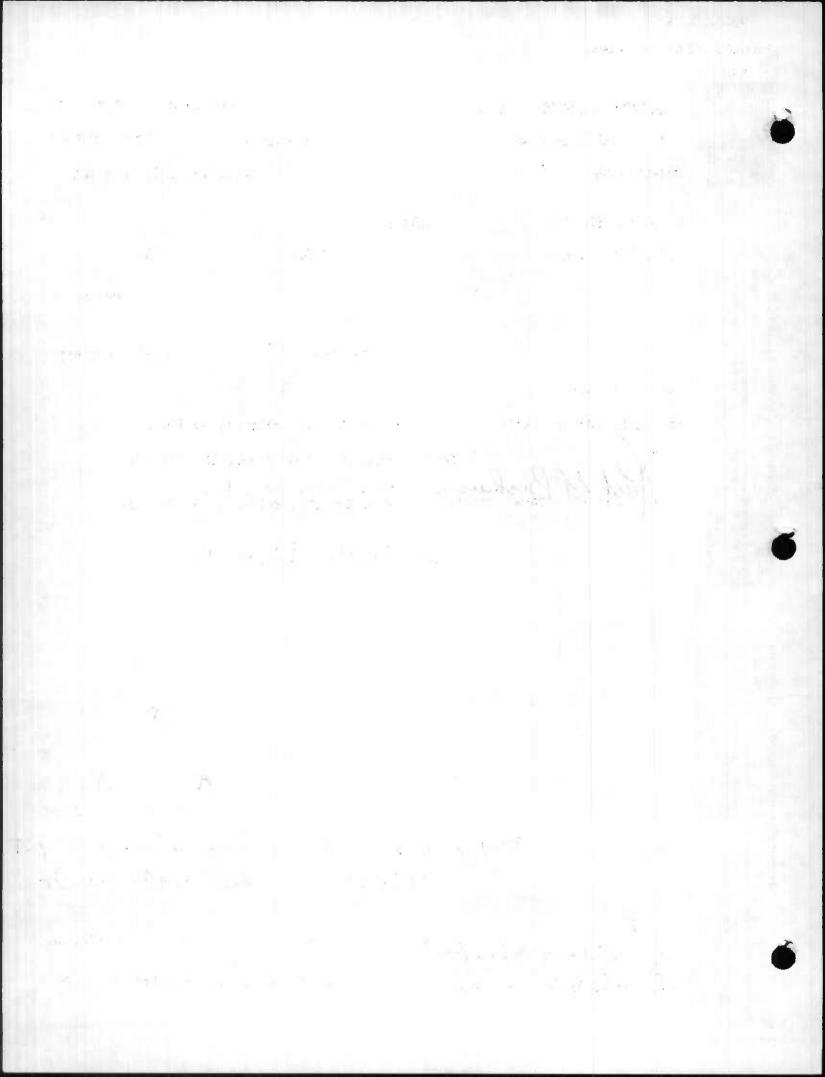
5 Panding

Investigation

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State Registrar

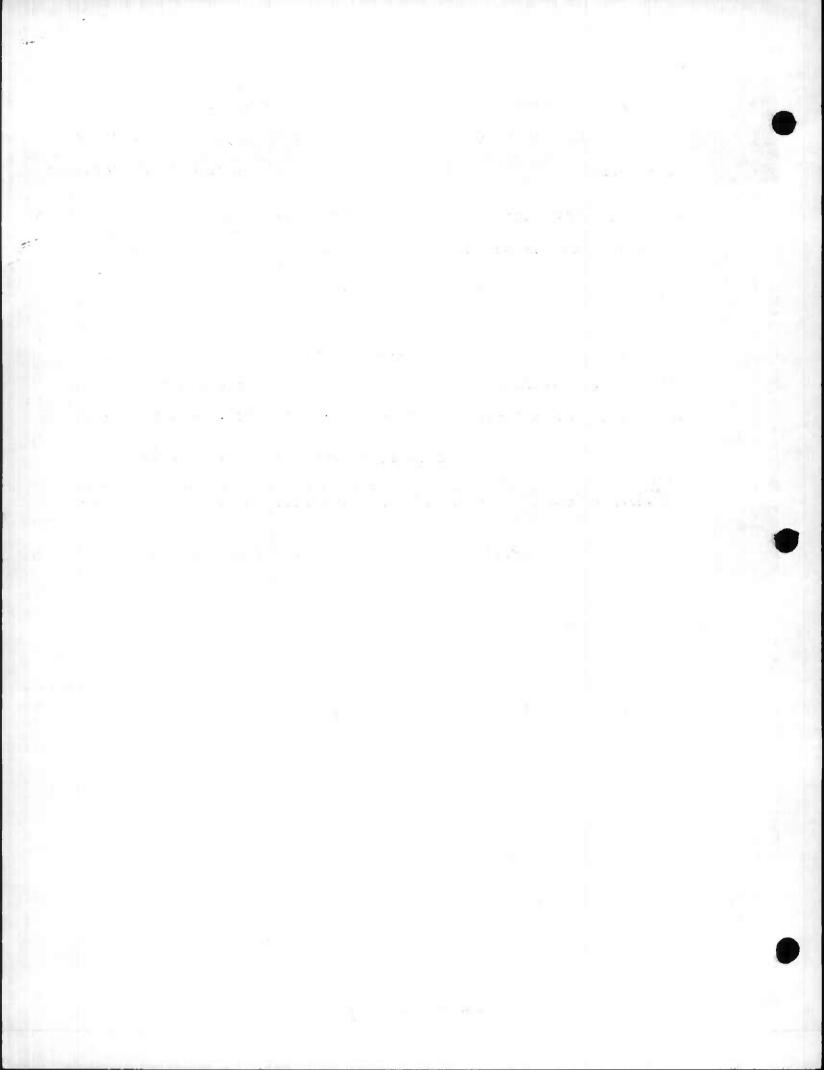
SEP 16 1998 32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

29404

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Physici /Media		Olive W. Sim	mons							Sept.	11, 19	98	6:00 pr
Examir		4e. Facility Name (If not institution, gi	va street and nu	mber)				4b. City, To	wn, or L	ocation of Deel	th 4c. Count	y of Deeth	
		Glasgow Nurs	ing Ho	me				Car	mbr:	idge	Do	rche	ster
Funeral		5. Social Security Number 6.	Sex	7. Aga (In yrs. I	ast birthday)			If Undar	24 Hrs.	8. Data of Bi (Month, D	rth	9. Birth	place (Stata or Foreigntry)
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Ma Pr	to	Maryland Dorc	hester			Churc	ch	Cree	k				1 ☐ Yas 2 📉 N
h th	Director	10e. Straet and Numbar				10f. Zip (Coda				10g. Citizan of	What Cou	ntry?
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be filed within 72 hours after death with the Manylan tel Hygiene. Ide Hygiene. Ide Hygiene. Ide Madical Evaniner mail be notified at avent, the Madical Evaniner mail be notified at	Funeral	11. Marital Status		edant Evar in U,		Was Daceda	ant of H	lispenic Ori	igin? (Sp	acify Yes or N	o- 14. Ra	ce - Amari	can Indian,
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elf, o	by	3 X Widowad 4 ☐ Divorced	It Yas, Giv Yaar or D			1 Yas 2	No.	Specify:			Speci	y: Wh	ite
2 ho	Completed	15. Dacedant's E	ducation		16a. Dece	dent's Usual	Occup	ation			16b. Kind of 8	Business/Ir	ndustry
Ved a	ple	(Spacify only highast gr Elamantary/Secondary (0-12)	ada complated) College (1	L dor 5 t	(Giva life.	kind of work DO NOT use	k done a retire	<i>during</i> mos d)	t of work	ring			
Hygiene. ther than " ent, the Me	E	12	College (1-401 34)	Cr	ab P	ick	er			She	llfi	sh
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marked	ToE	Charles W. Wa	llace					N	ell:	ie Flo	wers		
marked o	-	19e. Intormant's Name/Reletionship	(Typa, Print)		19b. Maili	ng Address	(Straat	and Numbe	er or Rur	ai Routa Numb	per, City or Town	. Stete. Zi	p Coda) 2161
permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 is marked any Injury or other traumatic evonce.		Wallace L. Sim	mons/S	on								n, Stete, Zip Code) 216] Imbridge, MI	
Hearth		20a. Method of Disposition		20b. Pl	Placa of Disposition (Nama of amatary, crematory or other place)			Deta	20c. Location				
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hysician '					0							1	Onsat and Death
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ding physician and se es the buriel-transit	Ä	Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury		,									
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y the	hys	Part II. Other eignificant conditions		ain but not rasu	iting in the u	ndariying ca	usa giv	en in Part I	•		20.		o the cause of death
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ate has been signed by the etter page 2 should be detached for t	d by		0							24a Was	s an autopsy	24h W	ara autopsy tindings
been si	ete									peri	ormad?	6/	reileble prior to emplation of causa
has b	Completed											ot	death?
or death. ector: After this certificate haby the funeral director, page	S									10	Yas 2□No	1	□Yas 2□No
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h. After thi funeral		27. Manner of Daath 1 SNatural 5 □ Panding	28a. Data o	ot Injury	28b. Time o	t 28	c. Injur Wor				how injury occu		
r: Af	atic	2 ☐ Accident Invastigation	n		,,	M		Yas 2□	No				
ecto by ti	=======================================	3 ☐ Suicida 6 ☐ Could not be datermined	28a. Placa	ot Injury - At hor	ma, farm, str	aat, tactory,	office					ber or Run	al Routa Number,
i Di	Certification:	· O Homoda	Dulluli	ng, atc. (Spacity)						City of 10	wn, Stata)		
within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Cartifiar 1 CartifyIng Pl	nysician: To tha	best of my know	rladga, death	n occurrad at	t tha tin	na, date en	d place,	and dua to tha	cause(s) end m	annar as s	stated.
n 24	edicai	(Check only 2 Madical Example)	minar: On the be	asis of examinational states.	on and/or in	vastigetion, i	n my o	pinlon, dea	th occurr	rad at tha tima,	date and place	end dua t	o tha causa(s)
rothi comp	×	29b. Signatura and titla of certitiar				29c.	Licans	a numbar			29d. Date sign	ed (Month,	Day, Yaar)
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		30. Nama and eddress of person who	completed caus	e of deeth (Item			,	2.3	14	1 .	01610		
		Eyup Tanman, M.I				et, Ca	mbr	idge,	Mar	yland	21613		
Sta		31. Data filed (Month, Day, Year)		egistrar's Signati	ura	. /							
Registr	ar	SEP 15	1330		P	· Sp	Day	5					
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Box 68760

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Day Month Year **Physician** John A. Sutor 31, AUGUST 1998 0754AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 236 EAST MAIN STREET ELKTON CECIL COUNTY Hours Min. April 8, Dete of Birth (Month, Dex Year)

April 8, 1919 If Under 1 Yaar 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country),
 On10 **Funeral** Months Deys 1 M 2□ F 293-10-6546 79 Director Usuel Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show XXYes 2□No Md. Ceci1 Elkton Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, ins Medical Examiner must be 236 E. Main Street 21921 USA Funeral 12. Wes Decedent Ever in U,S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or flee any injury or other traumatic event, the Medical Evantinat once. Bleck, White, etc. 1 Never Married 2 Married Yes 2 No 1 ☐ Yes X☐ No Specify: Specify: White Ag 3 Widowad 4 □ Divorced Yaar or Datas: WW 2 Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Veteran Disabled 12 17. Fether's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumeme) No information available No information available 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Barbara Haley, Caregiver 105 W. Thompson Dr., Elkton, Md. 21921 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition Date 20c. Location - City or Town, Steta X Buriet 2 Cremetion 3 Remove from State Garrison Forest Cem. 9/9/98 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 259 E. Main St., oral Sec 22. Neme end Address of Fecility Gee Funeral Home Elkton, Md. ese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximete Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Final disaasa or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Examiner physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consaquance of) as use for ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 3 Probably 4 Unknown 1 ☐ Yas 2 ☐ No by 8 24b. Were autopsy findings aveilable prior to 24e. Wes en eutopsy performed? Completed completion of causa of deeth? page 2 INSPECTION 1 Yes 23€No 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medicel 28. Piece of Deeth (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 0 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? il or Attending P sefter deeth. f Director: After i 5 Pending investigation 1 Naturel Injury 1 Yes 2 No 2 Accident the 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide edical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Chick off) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sig nature and title of certifier O.C.M.E. SEPTEMBER 05, 1998 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

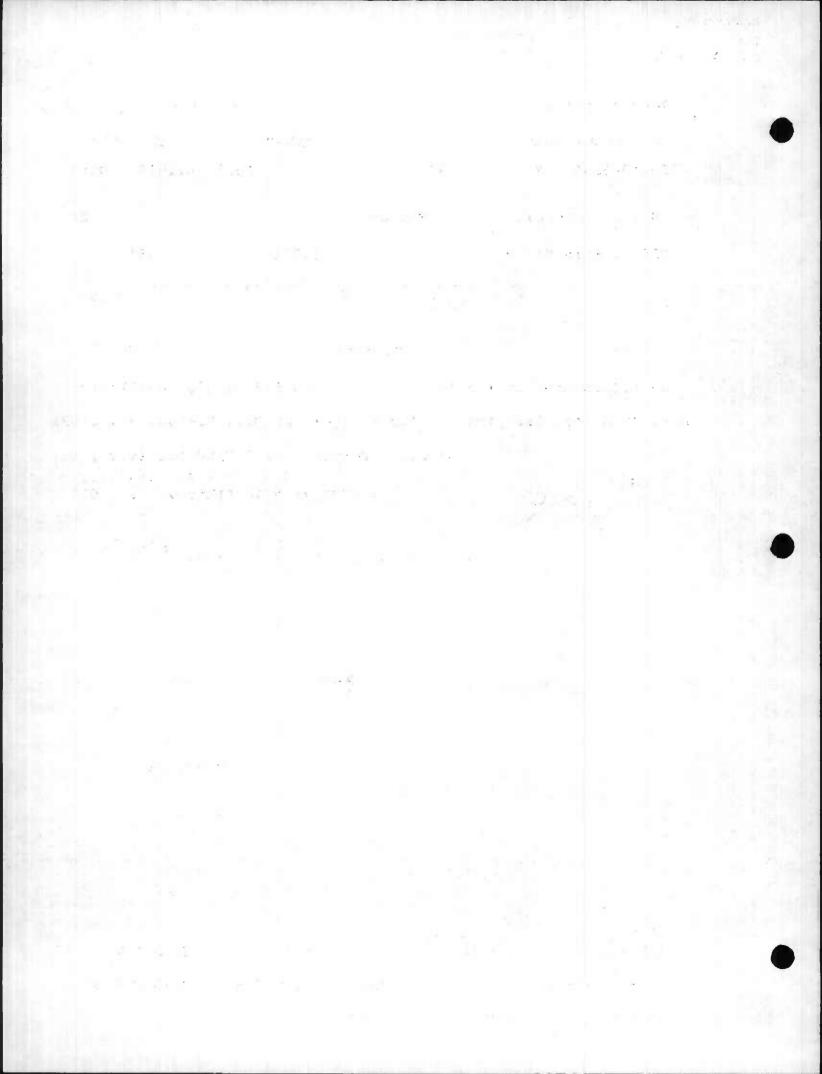
H+1VA

Laron Locke M.D.

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Dete filed (Month, Dey, Yeer) SEP 1 4 1998

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dev Month 3:30 am Madaline Katherine Shiflet September 10, 1998
4b. City, Town, or Location of Death
4c. County of Death 4s Facility Neme (If not institution, give street end number) Genesis Nursing Home -Annapolis Anne Arundel Spa Creek 8. Date of Birth (Month, Dey, Year) S. Birthpiaco (Country)
Oct 29,1913 Maryland If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Days 1 M 2 X F Months Hours 212-05-8683 84 Usual Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel 1 Yes 2X No Directo Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 835 Buena Vista Avenue 21012 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 Yes 2 No Specify: Specify: þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painting Elementery/Secondary (0-12) College (1-4or 5+) Paint Brush Maker 6 18 Mother's Neme (First Middle Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Mamie Dash Phillip Chapman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roy Shiflet, Jr., son 835 Buena Vista Avenue, Arnold, MD 21012 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State Sept 14 Crownsville, MD 1X Buriel 2 Cremetion 3 Removal from Stete MD Veterans Cemetery 1998 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Parranco & Sons, P.A. Severna Park 21. Scientire of Funeral 9 Funeral Home 95 Gov. Ritchie Hwy., Severna Park, MD 21146 not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause Final disease or coordion resulting in death) Mouth neumon Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequenca of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown þ

Physician /Medical Examiner

physician and the burial-transit

SB esn for

signed by the aid be datached f

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certificate

this

or Attending Physician:

Hospital

death.

after death Director:

n 24 hours after des re Funeral Director oletaly filled in by the

To the Hosp within 24 hor To the Fune completely fi

page 2 s has

funeral

the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

Completed

Be

Certification: To

edical

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mohell Hygiene.

This marked other than "natural", or fterme 23.

It from 27 is marked other than "natural", or therme 23.

Inty or other traumatic event, the Mouroal Example must

permit. Page Department of Important: If any Injury or

Baltimore, Maryland 21215-0020

with the Maryland

28a. Date of Injury (Month, Day Year)

24e. Wes en eutopsy performed?

24b. Were eutopsy findings evailable prior to completion of cause of death?

1 Yes 20 No 26. Place of Death (Check only one)

1 □Yes 2 □ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how Injury occurred

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stele)

(Check only one)

25. Was case referred to medical examiner?

1 Tyes 25 No

27. Manner of Death

1 Metural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

1 Contifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29c. License number

29b. Signature and title of certifier Drowns

5 ☐ Pending

investigation

6 ☐ Could not be determined

72036

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2108 Di Du uto Drive Chester, MD 21619 provie 5

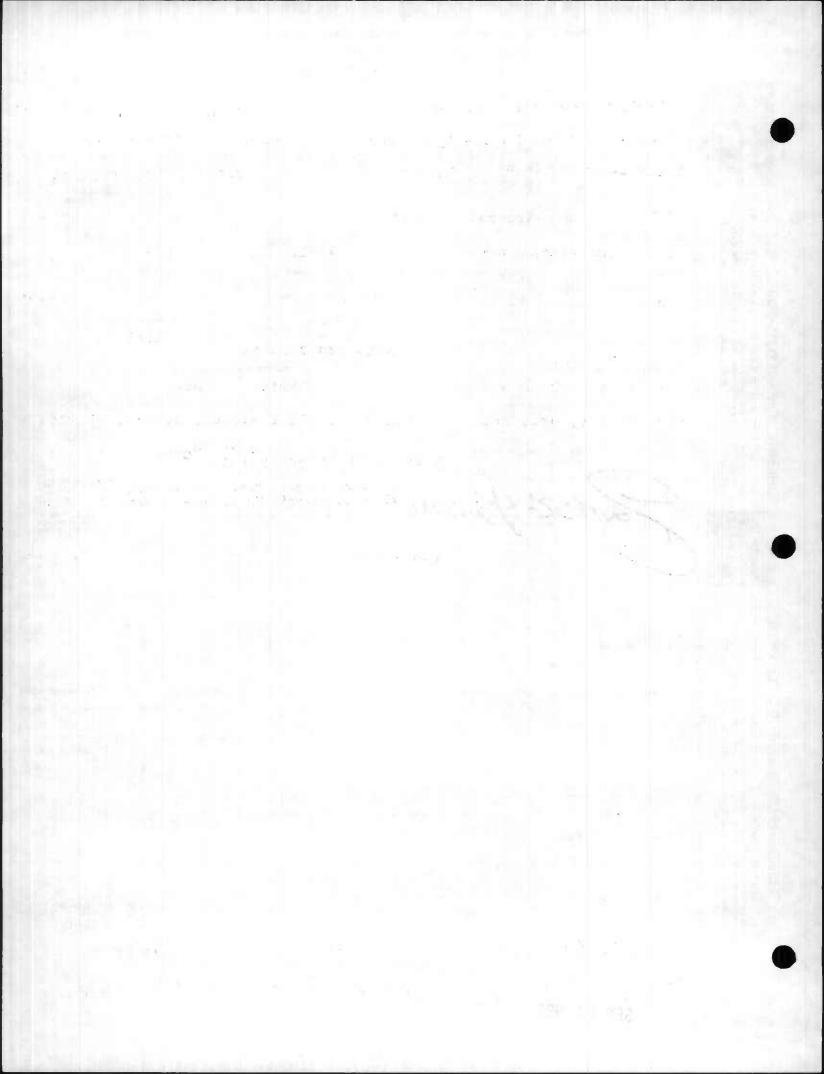
31. Date filed (Month, Day, Year) SEP 1 1 1998 Registrar

32. Registrar's Signeture

1 Inpatient 2 ER/Outpatient 3 DOA

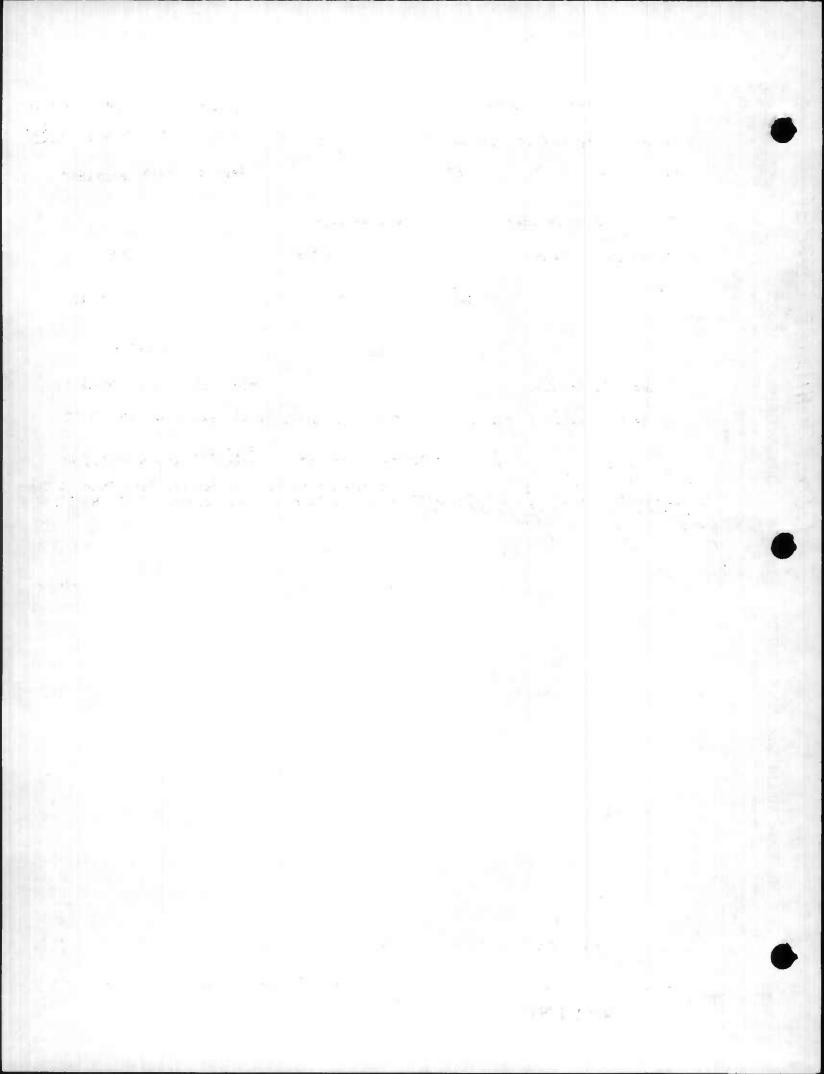
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of



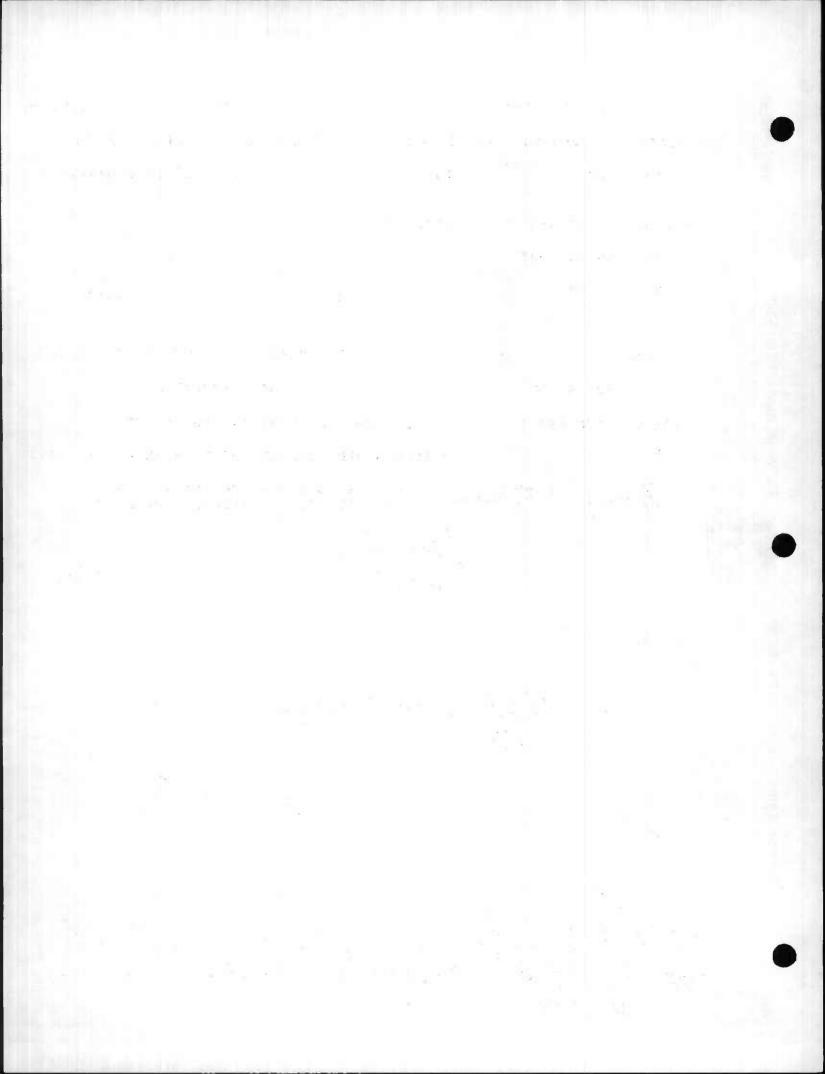
Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Registrar



-ioio-				Cen	ificate o	Dealli		Reg. No.	98 291
sician edical	1. Decedent's Name (First, Middle, AUREL:	Lest) IA SMITI	Н				2. Date of D Month SEPT.	Day	3. Time of 3:45
miner	4a Facility Name (If not institution,	give street and nur	mber)			4b. City, Town	, or Location of Des	th 4c. County	of Death
	ANNAPOLIS NUR	SING & 1	REHAB.	CENTE	R .	ANNAPO	LIS	ANNE	ARUNDEL
ral tor	5. Social Security Number 2 1 5 - 1 6 - 0 0 9 0	6. Sex 1 ☐ M 24 ☐ XF	7. Age (In yrs. la 8 7	est birthday) Yrs.	If Under 1 Yes Months Dey			irth Day, <i>Year)</i> 25 191	9. Birthplace (State of Country) O MARYLAN
	Usual Residence of Decedent								
	10e. State 10b. County		10c. City,	, Town or Loca	ation				10d. Inside Ci
ompleted by Funeral Director	MARYLAND ANNE	ARUNDEL	ANN	APOLIS	5				XIX Yes
- e	10e. Street end Number				10f. Zip Code			10g. Citizen of \	What Country?
al	229 ADMIRAL	DRIVE			2140	1		US	
Funeral	11. Maritel Stalus	12. Wes Dece Armed Fo	edent Ever in U,S	3. W	as Decedent o	f Hispanic Origin	? (Specify Yes or Noverto Rican, etc.)	lo- 14. Rac	ce - Americen Indian, ck, White, etc.
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced		2 X No		Yes 2X N		delle mount, etc.)		y: BLACK
8	15. Decedeni's	s Education		16a. Decede	nt's Usuel Occ	upetion		16b. Kind of B	usiness/Industry
Completed	(Specify only highest	grade completed)		(Give k	ind of work dor O NOT use reti	ne during most o	f working		
E	Elementary/Secondary (0-12)	College (1	1-4or 5+)		DO	MESTIC		OUT OF	THE HOME
Ö	17. Father's Name (First, Middle, L				DO		Name (First, Middle		
Be		SMITH				M	ARY THO	MPSON	
7				40h Mailine	Address /Ctm		or Rural Route Num		State Zie Code)
	19a. Informant's Name/Relationsh								
	TERRY SMITH (SON)	20h Di		WHITO ition (Name of	N COUR			D. 21401
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion	3 Removal from	ce ce	metery, crema	atory or other p	olace)	Date		- City or Town, State
	4 ☐ Donation 5 ☐ Other (Sp.		ANN.	APOLIS	S MEM.	GARDE	NS 9/12	198 ANN	APOLIS,
	21. Signature of Funeral Service L	icensee				tress of Facility	NO MODE	II A D SZ D	
	Harry L	1. X ee	se				NS MORT		
	23a. Part1. Enter the di sase, or o	complications that c	eused the death.	. Do not enter	the mode of d	lying, such es ce	NNAPOLI erdiac or respiratory	arrest,	Approximat
	shock, or heart failure. List of	nly one ceuse on e	ech line.		1 -				Interval Bet Onset and
	Immediate Cause (Final		10	1111	1				40
Ш	disease or condition rasulting in death)	a	000	vvu	y w				1
5			Dispersion for fore		I amount				0
			11	as a consequ	noe of):				Lec
늗		p. b.	H	5					yer
xamir	Sequentially list conditions,	P b.	Due to for	es a cousedn					yer
al Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to for	5					ger
dical	f any, leading to immediate cause. Enter Underlying	c	uno-on.ded	5	ence of):				ger
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dical	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events	c	uno-on.ded	as a consequ	ence of):				ger
dical	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events	d.	Due to (or	as a conseque	ence of):	given in Part I.	230.04	d tobacco usa co	Ger ontribute to the cause
Physician/Medical	if any, leading to immediate cause. Entire Underlying. Cause (Disease or Injury that initiated events resulting in death) Last	d a controluting to de	Due to (or	as a conseque	ence of):	given in Part I.		d tobacco use co ⊇Yes 2€ No	ger
Physician/Medical	if any, leading to immediate cause. Entire Underlying. Cause (Disease or Injury that initiated events resulting in death) Last	a acontroluting to de	Due to (or	as a conseque	ence of):	given in Part I.	10 24a We	Yes 27 No	3 Probably 4
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Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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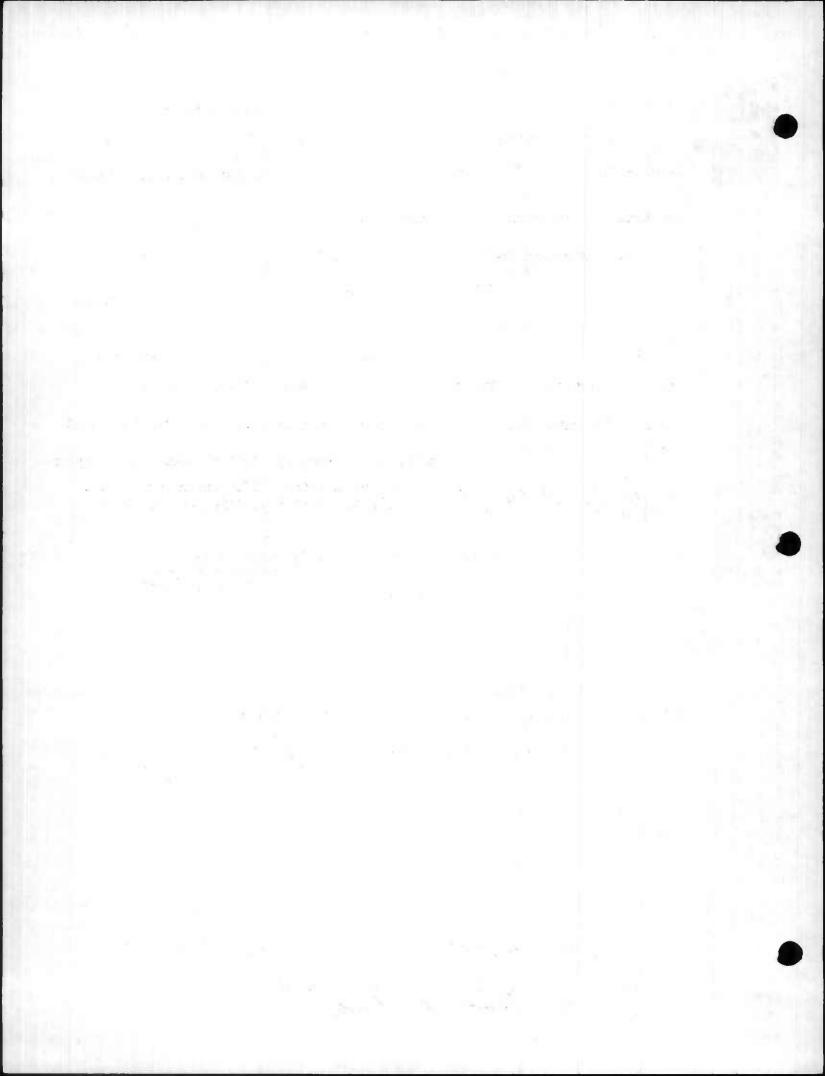
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Physician */Medical		RET M.	5/	4			2. Date of De Month	85	year 98	3. Time of Death
Examiner Funeral Director	North Arunde1 5. Social Security Number 6. 236-34-8021	Hospital	yrs. last birthdey, Yrs.) If Unc	er 1 Yeer	Glen Bur If Under 24 Hrs Hours Min	nie 8. Date of Bi (Month, De	Ann	9. Birthp	undel lace (Stete or Foreign try) souri
aryland show	Usual Residence of Decedent 10a. State 10b. County		. City, Town or L						1	0d. Inside City Limits 1 ☐ Yes 2 🕱 No
r 28a-f	Md. Anne A	rundel	Annap	-	ip Code			10g. Citizen of	What Coun	- AL
h wii	2614 Vantage Co	ve			214	40.1		US.	A	
72 hours after death with the Manyland naturel; or items 23s or 28s-f show dost Examinet must be notified at eved by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U,S. 13.			ispenic Origin? (sen, Mexican, Puer Specify:	Specify Yes or Norto Rican, etc.)		ce - Americ ck, White,	etc.
C	15. Decedent's (Specify only highest gi	rede completed) College (1-4or 5+)	(Give	e kind of t DO NOT	use retired	during most of we	orking	16b. Kind of B	usiness/Inc	lustry
filed within Hygiene. other than ent, the M		5+	Sch	1001	teach	ner		Sch	001	
Hal H	17. Father's Name (First, Middle, Las						me (First, Middle et Mary		n <i>e)</i>	
should by and Menta marked imatic events of To F	George Clayton F		10h Mail	ino Addre	ee (Stroot	and Number or F			State 7in	Code)
permit. Pages 1 end 2 should Depertment of Health and Mer Important: If Item 27 Is merke any Injury or other traumatic <u>ance.</u>	Alexander L. Slaf	Removel from State	2614 Ob. Place of Disp cametery, cre St. Man	Vant	age Clame of rother place	Cove A	nnapolis Date 9-8-98	20c. Location	21401 - City or To	
Physician /Medical Examiner	23a. Part1. Enter the disease, or cor shock, or heert failure. List only immediate Cause (Finat disease or condition resulting in death)	a. PSCUT Due MULT (death. Do not en	ter the m	ode of dyln	g, such es cardia	ster St.	Annap	olis,	Md . 21401 Approximate Interval Between Onset and Death
n certificate be executed anding physicien end use as the bural-transit manual transit edical Examiner		c. PARKIN	to (or as a conse	quence o	f):	SYNDL	ome			
death e atte ed for	Part il. Other significant conditions	contributing to death but not	resulting in the u	underlylng	ceuse giv	en In Part I.	23b. Did	I tobacco use co	ontributa to	the cause of death
requires that the death wen signed by the atter hould be detached for u							1□	Yas 20 No	3 Prol	bably 4 Unknow
aw lish 2 s S							24a. Wa: perf	s an autopsy formed?	av	ere autopsy findings allable prior to mpletion of cause death?
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Physician: The this certificate ral director, pag.: To Be Co	25. Was cese referred to medical examiner? 1 Yes 2 No	Hospital: 1521npatient	2 ☐ ER/Outpatie	ent 3	DOA Oth	or.	eath (Check only Home 5 Res		her (Specif	v)
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To the Hospital or within 24 hours after To the Funeral Discompletely filled in	29a. Certifier 12 Certifying P (Check only one) 2	hysician: To the best of my minar: On the besis of exen end menner steted.								
To the common of	29b. Signeture and title of cartifier	nvo.		2	9c. Licens D 2	e number 3 63 Z		29d. Date signe	ed (Month,	Dey, Year)
State	30. Name and address of person who	7575 32. Redigtrer's S	Richie I		ay hour	Glen Bu	rnie, Má	2106	1	

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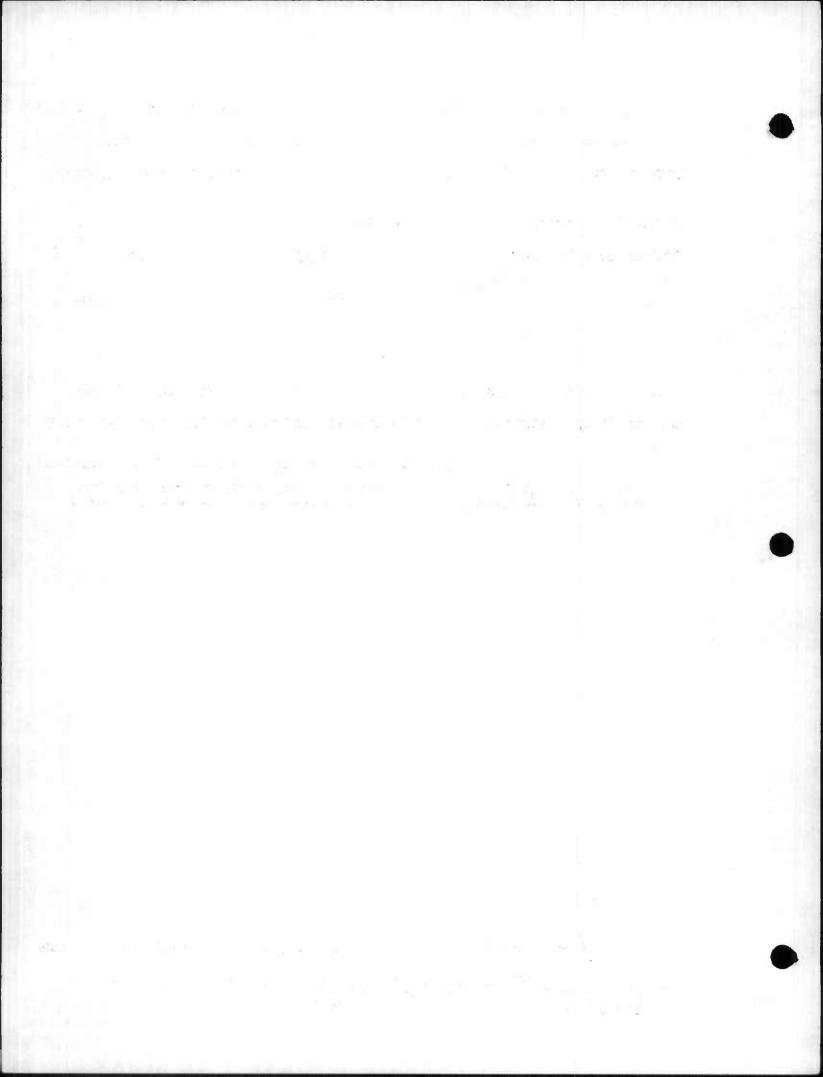
To Health and Mental Hygiane. If Item 27 is marked other than "naturel; or items 23s or 28s-f show and the marked other than "naturel; or other traumstic event, the Medical Examine must be notified at contract or other traumstic event, the Medical Examine must be notified at contract or other traumstic event, the Medical Examine must be notified at the property of	n il er	Margaret Na. Fecility Neme (If not Institution, give a 3510 South Mos. Societ Security Number 6. Sec.)	Lou street and numb			STEP	HENS	2. Dete d Month Septe		8, 199	
Examiner Funeral Director	r	3510 South Mo		ner)						09 11/	0.00
rector		5. Sociel Security Number 6 Sec	untain					m, or Location of I		ic. County of D Freder	
the notified at		216-52-7782	7. M 2⁄Q €F	Age (In yrs. le 86	est birthday) Yrs.	If Under 1 Y Months De	ear if Under 2 eys Hours	Min. 8. Dete control (Montil July	of Birth n, Dey, Yea y 23,	"1912 ^{9.}	Birthplace (State of Country) Marylan
No or 28		Usual Residence of Decedent 10e. Stete 10b. County Maryland Frede	erick	10c. City	Town or Loc						10d. inside C
	DIE	10e. Street end Number 3510 South Mounta	in Posé	1		10f. Zip Cod	21758		10g. (Citizen of What	Country?
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nt, the Medical of the Completed	completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cetion e co <i>mpleted)</i> Coilege (1-4	or 5+)	(Give I life. D	ent's Usuel Oc tind of work do O NOT use re maker	one during most	of working	16b.	Kind of Busine	ess/Industry Home
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To the Funeral Director: After completely filled in by the fune medical Certification		3 ☐ Suicide 6 ☐ Could not be determined	building	injury - At hor , etc. (Specify))			City o	r Town, Ste	ete)	r Rural Route Num
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene (

		1. Decedant's Nama (First, Middla,	Last)						2. Date of Death Month	n Dey	Year	3. Time of De
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THE S	0	Maryland Har	ford		Bel	Air						1 Yas 2
a not	9	10e. Street and Number				10f. Zip Co	de		10	Og. Citizen of V	Vhat Count	try?
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Important: If Item 27 is marked other than "retural; or items 23s or 28s-f show any injury or other traumatic event, the Marital Examiner must be notified at onde. To Re Commissed by Financial Director	2	11. Maritel Status 1 Never Merried 2 Marrie 3 Widowed 4 Divorced	Armed Fo	2 ⊡ 1No ⁄a			of Hispanic Orlo Cuben, Maxican No Specify:		cify Yas or No- Rican, atc.)		e - Amarica ok, Whita, a	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death September 11, 1998 **Physician** ALLEN SMITH 2:35 P.M. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert County Nursing Center Calvert 6. Sex 1 → M 2 □ F 8. Date of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign Country) Washington, D. C. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 88 Yrs. Director 212-14-7505 Usual Rasidence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Medical Examinar mant be notified at Calvert Maryland Dunkirk 1 ☐ Yas 2 X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10050 Howes Road 20754 USA death Funeral 12. Was Decedent Ever in U,S. Amped Forces? 1 ∰ Yes 2 □ No 1944— If Yas, Giva Year or Datas: 1946 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status Race - Amarican Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiena. Important: If item 27 ie marked other than "natural" any injury or other treumatic excessions. 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Board of Education Elamantary/Secondary (0-12) Coilege (1-4or 5+) Custodian 18. Mothar's Name (First, Middla, Maiden Sumame) 17. Father's Name (First, Middla, Last) Smith Maud Rosie Hicks 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Joseph A. Smith, Jr./Nephew 3829 13th St. NW Washington, D.C. 20011 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Cooper's UMC Cemetery 9/19/98 4 ☐ Donation 5 ☐ Othar (Specify) Dunkirk, MD 21. Signatura of Funaral Sarvice Licensea 22. Name and Address of Facility Sewell Funeral Home Rodyn a. 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Interval Batwean Onset and Death **Physician** STENOSIS /Medical Immediata Causa (Final 1 EOR disease or condition rasulting in death) Examiner Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Ze hours after death.

Linear Director: After this cartificate has been signed by the attending physician and takey filled in by the tunental director, page 2 should be detached for use as the bunal-transit attending physician and for use as the burial-transit Sequantially list conditions, if any, leeding to immadiata causa. Entar Underlying Ceuse (Diseese or injury that initiated avents rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 25. Was casa rafarred to medical Be 28. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at / Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding 1 Tyes 2 No invastigation 2 Accidant 3 Suicida 8 Could not be datarmined 28e. Place of Injury - At homa, ferm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and piace, and dua to the cause(s) and manner as stated.

United Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and piace, and due to the cause(s) and manner stated. Medical 29a. Cartifiar

P.O. Box 68760. Records, Division of Vital To the Hospital within 24 hours a To the Funeral Completely filled

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State Registrar 29b. Signature and titla of

Charles Judge, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signatura

30. Nama and address of passon who complated causa of daath (Itam 23a) (Typa, Print)



29c. Licansa number

Prince Frederick, MD 20678

29d. Date signed (Month, Day, Year) CK

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State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Yaar **Physician** Jessie Geraldine Shelton September 10, 1998 12:50 p.m. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Prince George's Lanham If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Days 1□M 2XF Months Hours 577-10-8197 82 **Director** March 11, 1916 Washington, DC Usuel Rasidenca of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23a or 28a-f shorting at 1 Yas 2 □ No Directo Maryland | Prince George's Lanham 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? death with 6030 Cipriano Road 20706 U.S.A. Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amaricen Indian, 11. Marital Status 12. Was Decedant Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Black, Whita, etc. filed within 72 hours aftar Hygiene. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: by 3 XWidowed 4 □ Divorced White Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Homemaker Own Home . Pages 1 and 2 should be filed viment of Health and Mental Hygie ant: If item 27 is marked other thury or other traumstic event, in 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be John Paris Sarah Elizabeth Suit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mary Ann E. Amstutz - Daughter 10122 Brock Road, Spotsylvania, Virginia 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Department of Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specity) 9/14/98 Brentwood, Maryland Fort Lincoln Cemetery 21. Signature di Funeral Service Lici 22. Nama and Addrass of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or head failure. List only one cause on each line. Approximata Interval Batwaan Onsat and Death **Physician** · Ceresto Vascerlas /Medical Immediata Cause (Final disaasa or condition rasulting in daath) **Examiner** Examiner burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury that Initiated avants rasulting in daeth) Last and Dua to (or es a consaguance of) certificate be exec Lension physician a Physician/Medicai Dua to (or as a consequence of) 88 9SH 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performad? 24b. Wara autopsy findings available prior to Completed peen complation of ceusa of daeth? page 2 has 1 Yas 2 No 8 confine Be 25. Wes cesa refarred to medical exeminer? 26. Placa of Death (Check only ona) 1 Yes 2 No Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) To 1 Inpatiant 2 ER/Outpatiant 3 DOA 200 eral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? Attor Attending Matural 5 Panding J or Attending after death. Director: Att 1 Yas 2 No Invastigation 2 Accidant 6 Could not be datamined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida Funeral 29a. Certifier Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated. edical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta end piece, end due to the ceuse(s) and manner stated. To the 8 29b. Signature and little of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) no 034721 September 11, 1998 Nama and addrass of person who completed ceuse of deeth (Item 23a) (Type, Print) Vicken Poochikian, M.D., 5632 Annapolis Road, Suite 3, Bladensburg, MD 32. Registrar's Signature 31 Date filad (Month, Day, Year)

Registrar

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SEP 1

State of Maryland / Department of Health and Mental Hygiene Q 2

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** 10.15 AM ber 9 1998 Leonard B. Sligh 015-/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva streat and number) Examiner Takoma Park Montgomery Washington Adventist Hospital If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1XM 2□ F Months Yrs. Director South Carolina 247-26-0712A 80 8 - 2 - 18Usual Rasidanca of Dacedani the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show Yas 2 No Director MD Prince George's Hyattville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? *natural*, or items 23a or address Examiner must be 6500 Riggs Road 20783 USA deeth Funeral 12. Was Dacedant Evar in U,S. Armed Forcas?

1X Yes 2 No if Yas, Giva Yaar or Datas: 1942 Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Reca - Amarican Indien. 11. Marital Status Black, Whita, atc. filed within 72 hours efter 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3X Widowad 4 □ Divorcad Completed Decedant's Usual Occupation
 (Giva kind of work done during most of working life. DO NOT use retired) Pages 1 end 2 should be filed within 72 ho nent of Health and Mentel Hygiene. Int: If item 27 Is marked other than "natur ury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) Hotel 8th Bell Man 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Sim Sligh Martha Burton 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1911 Savannah St., S.E. #304 Wash., DC Data 20c. Location - City or Town, Stata Mary L. Price, Niece 20020 20b. Piace of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 2 Cramation 3 Ramoval from Stata Maryland Vet. Cemetery9-16-98 Cheltenham, Md. pemit. Page Depertment Important: If eny Injury or once. 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signatuje of Funeral Service Licens Ralph Williams Funeral Service Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one ceuse on each line. 20003 Approximata Intarval Batwean Onset and Daath Physician Immediata Causa (Final disaasa or condition resulting in death) /Medical neuman 9 Examiner Dua to (or as a consaquance of): Examiner physician end s the buriel-transit Sequantially list conditions, if any, leeding to immadiata causa. Entar Undarlying Ceuse (Disease or Injury that initieted avants rasulting in death) Last Dua to (or as a consaquance of): Box 68760. certificate be Physician/Medical Dua to (or as a consaquance of): 80 ettending p signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yas 2 No 3 Probably 4 WUnknown Division of Vital Records. by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? page 2 s 188 1 Yas 2 No 1 Yas 2 No certificate Physician: director, 25. Wes case rafarrad to madical axaminar? Be 28. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidance 8 Other (Specify) To 1 Yas 2 No this funeral 27. Menner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 28a, Data of Injury (Month, Day Year) Certification: After 1 Natural 5 Pending 1 Yas 2 No deeth. 2 Accidant efter deetl Director: 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stata) 28e. Pleca of Injury - At homa, ferm, street, factory, offica building, atc. (Specify) 2 4 - Homicide 6 filled in Hospital 24 hours Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medicat Examine: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and due to the ceuse(s) and due to the ceuse(s). 29e. Cartifiar Medicai tely ar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. (Check only one) To the To the To the Comple 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licensa number s of person who complated causa of death (Itan-23a) (Typa, Print) 30. Nama and addras owie 2. Registrar's Signatura 31. Data filed (Month, Day, Year) SEP 1 1 1998 Registrar

DHMH 16 Rev 6/95

SPELLERS JAMES JAMES

State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Deeth **Physician** Month Sami 50 0550 a /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Cross NOSDIY Spring Solver Montpomer 8. Dete of Birth (Month, Dey, Y 1-26-46 5. Sociei Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign
Country) **Funeral** Months Deys Hours Egypt 1 M 2 XF 146-68-2476 52 Yrs. Director Usuel Residence of Dacedent the Marylend 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits show Examiner must be notified at Maryland Montgomery Director Kensington 1 XYes 2 No 288-1 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ö 3127 Jennings Rd. 20895 USA Items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bieck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) permit. Pages 1 end 2 should be filed within 72 hours after a Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Event once. 1 ☐ Yes 2 🛣 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 Specify Egyptian 1 Yes 2 X No by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Embassy Accountant 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Ahmed Sayed Fatima Omara 19e. Informent's Neme/Raietionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) Dorry Mohsen 3127 Jennings Rd, Kensington, Md. 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crametory or other plece) 20c. Location - City or Town, Stete Dete 1X Buriel 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemet. 9-5-98 Adelphi, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility UNIVERSAL MORTUARY INC. 411 Kennedy St, N.W., Washington, D.C. Part 1. Entar tha diseasa, or complications thet caused tha death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete **Physician** /Medical Immadiata Causa (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner iclan end burial-transit The law requires that the death certificate be executed Sequentielly tist conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated evants resulting in deeth) Lest Due to (or es e consequence of): physician of the burial Records, P.O. Box 68760. Be Completed by Physician/Medical Due to (or es e consequence of): for use Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably A Unknown 24b. Were autopsy findings eveileble prior to completion of causa of daath? 24e. Wes en eutopsy performad? page 2 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes cese referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 5 Panding after death.

Director: Aft
d in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours a Hospital a. Certifier 1 Certifying Physician: To the basis of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner es stated.

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State Registrar 31. Dete filed (Month, Dey, Year) SEP 0 8 1998 32. Pegistrer's Signeture

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		State of Mary	Ce	rtificate o	f Death		Reg. No.	-	2411
	1. Decedent's Name (First, Middle, Las		2-11			2. Date of Dec		Vess	3. Time of Death
Physician /Medical	Charles Stul	ces				Sept.	Day 5	Year 1998	12:00 PM
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Death	4c. County	of Death	
	2164 Alice Ave.	#201			Oxon H	li11	Prin	ce Geo	orge's
Funeral	5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Day			, Year)	9. Birthple Count	ace (State or Foreign
rector	237-16-9825	8	O Yrs.			Oct. 20	1917		n Carolina
	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10	Od. Inside City Limits
by Funeral Director	Maryland Prince Ge			on Hill					17 Yes 2 □ No
Director	10e. Street end Number			10f. Zip Code			10g. Citizen of	Whet Count	Iry?
	2164 Alice Ave	#201			20747				
Funeral	11. Marital Status	12. Wes Decedent Ever	in U,S. 13.	Was Decedent o	f Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No-		United States 14. Race - American Indian,	
	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □XYes 2 □ No				erto Rican, etc.)		Black, White, etc.	
by	3 ☐ Widowed 4 ☐ Divorcad	If Yes, Give Year or Dates:		1□Yes 2√√N	lo Specify:		Speci		ack
Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usuel Occ	ne during most of w	orking	16b. Kind of B	ustry	
Jdm	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	ired)				
Co	12th			Laundry	y Foreman			overn	nent
Be Se	17. Fether's Name (First, Middle, Last) Thomas Stukes				15. MUTHET'S N	ame <i>(First, Middl</i> e, Hattie		10)	
To	19a. Informent's Name/Reletionship (7	Tuna Brint)	10h Maili	na Addraga (Ctra	eet and Number or F			State 7in	Codel
trau	Jessie P. Thigpen								20747
in a	20a. Method of Disposition		Ob. Plece of Dispo	sition (Neme of		Date	20c. Location		
y or	1 Burial 2 Cremation 3 D			matory or other p		0/11/00	Testere	1 - 1/2	
Department of Health end Mentel Hygiene. Important: If Item 27 Is marked other than "naturel", or Items any Injury or other traumatic event, the Medical Examines manages. To Be Completed by Funer	4 □ Donation 5 □ Other (Specify 21. Signature of Funerel Service Licen			Nationa 2. Name and Add	1 Cemete:	ry/ 11/98	Triang	gie vii	rginia
and and	NO TO	- 8 11	-		. 5	Stewart F			
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ysician Medical aminer	Immediate Cause (Final disease or condition resulting in death)	Due	to (or es a conse	quence of):	Jen I	14.79			Onset end Deeth
Examiner	Sognestially list conditions	U.	mer Sync						
	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying		ension	4001100 01).					
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dint	4 Homicide	building, efc. (S)	pecify)			City or Tov	m, State)		
completely filled in by the fune Medical Certification		rsician: To the best of my inar: On the basis of exar and manner stated.							
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To the Funeral completely filled Medical C	30. Neme and address of person who o	completed cause of grant	(Item 23a) (Type,	Print)	0///		Dopec	moci	0, 1770
within 24 hours after death. To the Funeral Director: After this certification, completely filled in by the funeral director. Medical Certification: To Be (30. Neme and address of person who of Muhammad Yusuf	completed cause of death			ve., S.E.	, #210:			20020

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State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

Funeral Director

with the Marylend 28a-f show treumetic event, the Medical Examiner must be notified at ò Items 23a permit. Pages 1 and 2 should be filled within 72 hours effer to Department of Health and Mental Hygiene.
Important: If item 27 is marked and Jujury or other 27 is marked and Jujury or other 27 is marked and Jujury or other 27 is marked and Jujury or other 27 is marked and Jujury or other 27 is marked and Jujury or other 27 is marked and 30 millions or other 27 is marked and 30 millions or other 27 is marked and 30 millions or other 27 is marked and 30 millions or other 27 is marked and 30 millions or other 27 is marked and 30 millions or other 30 mi

> **Physician** /Medical **Examiner**

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Division of Vital Records. death. or Attendiate after death Hospital 24 hours a Funersi C office of the 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death SEPTEMBER 04 1998 1845 P PATRICK XAVIER SMITH 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death MARTIN LUTHER KING AVE & 92nd **GEORGES** AVE PRINCE Lanham 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys 10 M 2□ F Months Hours Min 231-35-6384 27 December 15, 1970 Cheverly, Maryland Usual Residence of Decedent 10e State 10b County 10c. City. Town or Location 10d. Inside City Limits Maryland Prince George's 1 ¥ Yes 2 □ No Mitchellville Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1100 Mission Hills Drive 20721 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No It Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 10 Yes 2 No Specify: Hispanic Specify: Black þ 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decadent's Education (Specify only highest grade completed) 16a, Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Technician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Χ. Smith Athaena Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis X. Smith/Father 1100 Mission Hills Drive, Mitchellville, MD 20721 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, crematory or other pleca) 20c. Location - City or Town, State 09/09 Lincoln Memorial Cemetery 1998 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 er cer 23a. Part1. Enter the dis-use, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca ot): Physician/Medical Due to (or as a consequenca ot) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy Completed 2□ No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Be Hospital: XXYes 2 No Other: 4 Nursing Home 5 Residence 6 KOther (Specify) SCENE 2 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Menner ot Deeth 28b. Time of 28c. Injury at Work? Certification: 28 notorcyclist struct auto 1 Natural 5 Pending investigation Placa ot Injury - At hom building, etc. (Specify) 2 Accident 3 ☐ Sulcide 755 (Street end Number or Rural Route Number, 6 Could not be me, tarm, street, fectory, offica 4 Homicide martin 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified SEPTEMBER 05,1998 O.C.M.E end address of person who completed cause ot death (Item 23a) (Type, Print) MD ARON LOC

Registrar

31. Date tiled (Month, Day, Year) **SEP 0 9 1998** 32 Registrar's Signature

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111 Penn Street, Baltimore, Maryland 21201

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200. Method of Disposition XIS Burial 2 Dicemetron State Rocky Springs Cemetery Sep 14,1998 Frederick, Maryla All Denairon Silver (Specify) Rocky Springs Cemetery Sep 14,1998 Frederick, Maryla 21. Signature Funeral Service License MO0700 MO0700 For Church Street, Maryland 22. Same and Address of Feality Reeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 21. Signature Funeral Service License MO0700 For Church Street, Frederick, Maryland 22. Same and Address of Feality Reeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 21. Signature Funeral Service License MO0700 For Church Street, Frederick, Maryland 21. Signature of License Bridge and Charles MO0700 For Church Street, Frederick, Maryland 21. Signature of License Bridge and Charles MO0700 For Church Street, Frederick, Maryland 21. Signature of License Bridge and Charles MO0700 For Church Street, Frederick, Maryland 22. Same and Address of Feality Reeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 22. Same and Address of Feality Reeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 22. Same and Address of Feality Reeney & Basford P.A. Funeral Home 106 E Church Street, Frederick MO0700 For Church Street, Frederick MO0700 For Church Street, Frederick MO0700 For Church Street Immediate Cause (Fine decision of Church Ch	2 E D 2	Be				Schul	tz				(First, Middle,			DEBRAND
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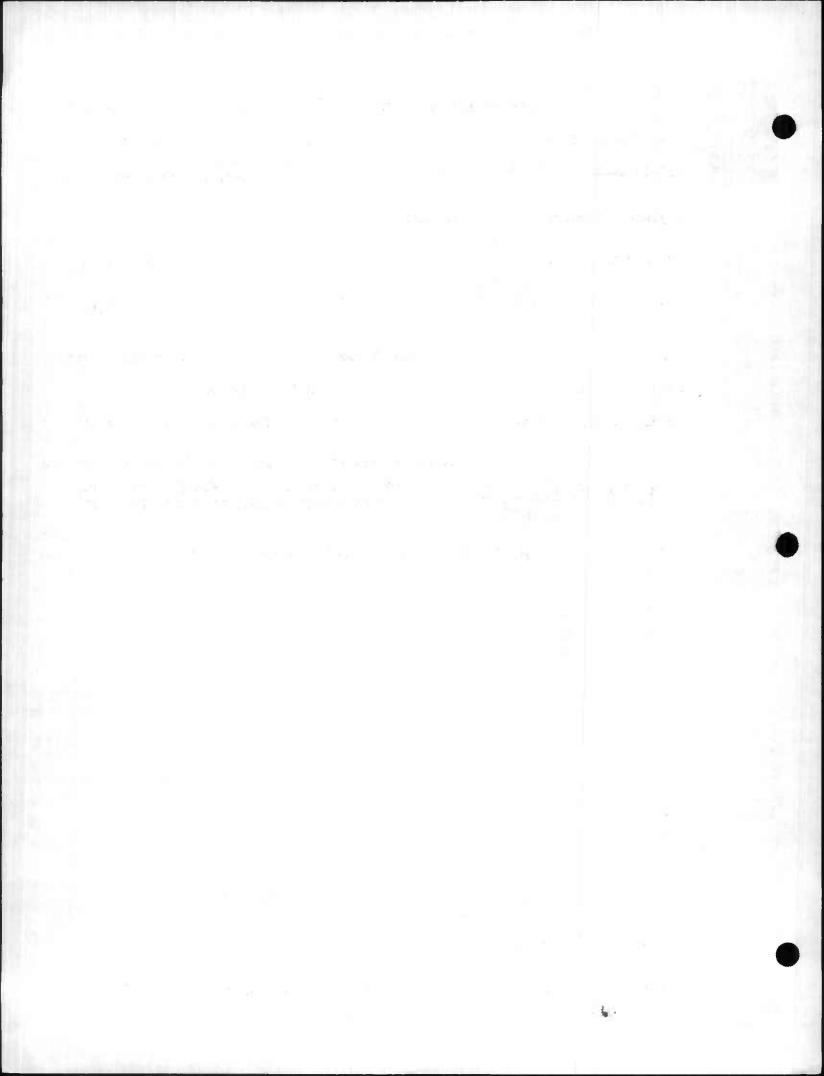
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State of Maryland / Department of Health and Mental Hygiene

ITEMS: #5 PER F.H. G764 10-6-98 WR. Certificate of Death 1. Decedenl's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month WOODROW WILSON SMITH September 10, 1998 6:15 AM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 10910 Putman Road Thurmont Frederick If Undar 1 Yaar If Under 24 Hrs. 5. Sociei Security Number 7. Aga (In yrs. iast birthday) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Birthpiece (State or Foreign Country) 217-10-00470048 Hours 1∭M 2□ F Yrs Director Oct. 28, 1913 Maryland Usuel Residence of Decedeni the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Maryland Frederick Thurmont Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 10910 Putman Road 21788 U.S.A. death Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 Never Marriad 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 ρ Specify 3 Widowed 4 □ Divorced "natural", White Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elemantery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Depertment of Health and Mental Hygien. Important: If item 27 is marked other that any fujury or other traumatic event, if a page. 8 Tool Maker Electric Company 17. Fether's Name (First Middle Last) 18. Mother's Neme (First, Middle, Malden Sumema) James Lee Smith Celeste Baugher 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Donald L. Smith (Son) 10906 Putman Road, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Maihod of Disposition 20c. Locailon - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) Resthaven Memorial Gardens 9/14 Frederick, Maryland 21. Signeture of Funerel Service Licensae 22. Name end Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Pert1. Enter the disease, or complications that causad the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) METASTATIC ADENOCARCINOMA OF COLON Examiner Due to (or es e consequence of): physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or injury Ihel initieted events resulting In deeth) Lesi Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of) use as Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown signed t Records, by 24a. Wes en eutopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed peed page 2 s 272 NO 1 Yes 2 No certificate Division of Vital 25. Wes case learned to medical exemples 1 To the Hospital or Attanding Physician: within 24 hours efter death.

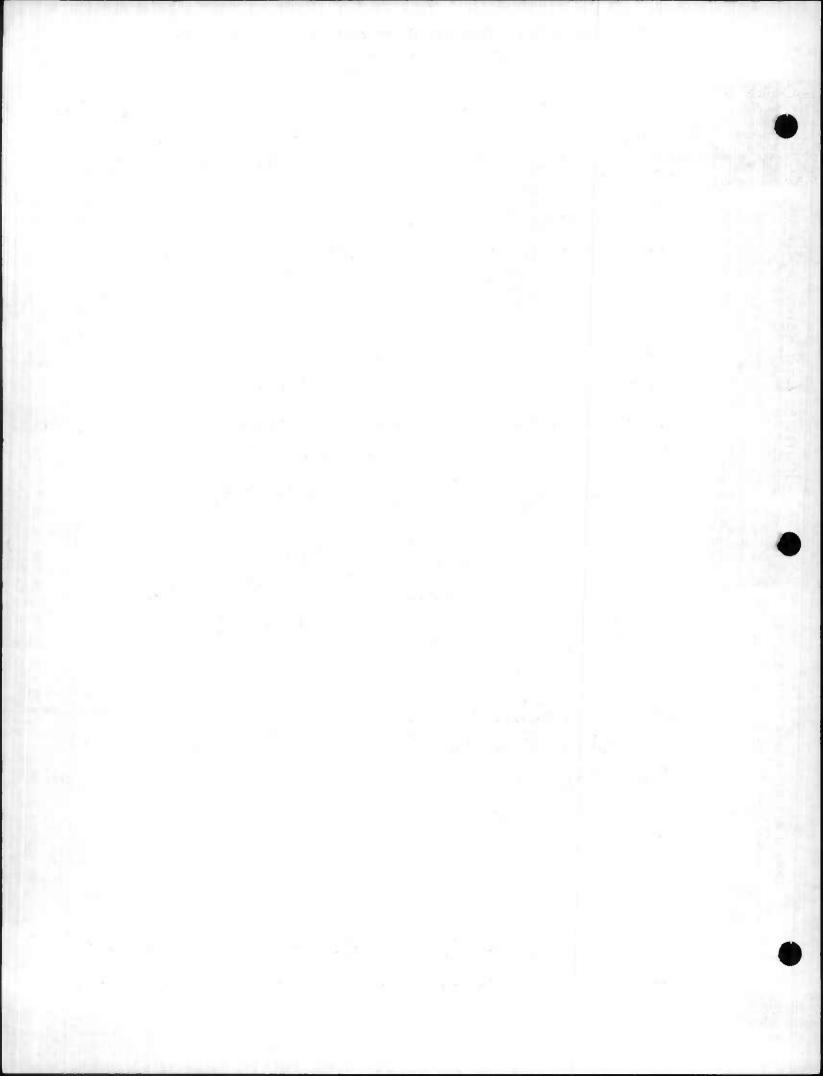
To the Funeral Director: After this certifica completely filled in by the funeral director; p Be 26. Place of Deeth (Check only one) Hospitel: 1 Yes 20 No Other: 4 Nursing Home Residence 6 Othar (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menger of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? after death. 5 Pending investigation 1/2 Neturel 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/ Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end plece, end dua to the ceuse(s) end menner as steted.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et tha time, date end place, end due to the causa(s) and menner stated. 29e. Certifier 29b. Signalure and title of certifier 29c. License number 29d. Date signad (Month, Day, Year) Sept. 11, 1998 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Brian O'Connor, MD 510 West Seventh Street, Frederick, Maryland 21701 32. Registrer's Signeture State Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death SEPTEMBER **Physician** Month James Lancaster Thomas, Sr. Q 10-98 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Civista Medical Center La Plata Charles H Under 1 Yaar | H Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | Month Day Year) | Man Ch 4, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign Country)
Maryland **Funeral** Sew 1EDM 2□F 213-22-2169 80 Director Yrs. Usual Residence of Decedent death with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show 1 Yes 2 No **Funeral Director** Charles Newburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10585 Mt. Victoria Rd. 20664 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amarican Indian, Black, White, etc. other traumatic event, the Medical Examiner 1 Naver Married 27 Married Specify: Black ò 1 Yes 2 No by 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Peges 1 and 2 should be filed within Department of Health and Mantel Hygiane. Important: If Item 27 Is marked other than any injury or other traumatic event, ine Ma Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming Maryland 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maldan Surname) Arthur Thomas Ida Colbert Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Veney/Daughter 9385 Bel Alton Newtown Rd. Bel Alton, MD20611 altimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Buriai 2 Cremation 3 Removal from State Holy Ghost Cemetery 9/14/98 Issue, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Nama and Addrass of Facility AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 I.A PLATA, MD 20646. Shock, or haart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Causa (Disease or injury that initiated events resulting in daath) Last and Due to (or as a consequence of): Box 68760 ettanding physiclen Physician/Medical tha Due to (or a a consequenca of): Division of Vital Records, P.O. been signed by the e should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 25. Was case referred to medical 2 No 1 ☐ Yes 2 ☐ No spital or Attending Physician: Theors after death.
neral Director: After this certificate y filled in by the funeral director, pa Be 26. Placa of Daath (Check only one) examinar? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Dimpatient 2 □ ER/Outpatient 3 □ DOA Certification: 28a. Date of injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Naturai 5 Panding investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be datarmined 28a. Place of Injury - At home, farm, streat, factory, offica building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral Completaly filled Hospital 12 Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and piace, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at tha tima, data and piace, and dua to the causa(s) and mannar stated. Medical 29a. Certifier 29b. Signature and title of cartifier 29c. License number 29d. Data signad (Month, Day, Year) 100001 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Henry L. Burke, MD 115-A La Grange Avenue P.O.Box 2539 La Plata, Maryland 20646 31. Date filad (Month, Day, Year) 32. Registrar's Signatura State SEP 14 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Пау Month **Physician** Emerson Allen Taylor September 5, 1998 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 140 Wesley Street Elkton If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. NOW 2DF Director 222-12-1251 72 April 12, 1926 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director notifie Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or Funeral 75 Fox Chase Drive 21921 United States 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Rece - American Indian, Bleck, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Specify: White 1 Yes 2 No Specify: h 3 29 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) Foreman Containers 10 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fall ment of Health and Mental H ant: if them 27 is marked oth lary or other traumatic even 88 Henry Taylor Ethel McConnell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. Taylor/ son 75 Fox Chase Drive, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete September 9, 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Philadelphia Memorial 4 ☐ Donetion 5 ☐ Other (Specify) 1998 Fraser, Pennsylvania 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Hicks Home for Funerals, P.A. else ared, 103 West Stockton Street, Elkton, Maryland 21921 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Hoens. Examiner 425. Examiner roncory burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest pue Due to (or as a consequence of): physician s the burial Physician/Medicai Due to (or es e consequence of): USB Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 1 Yaa 2□ No 3 Probably 4 Unknown þ sign be 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? page 2 certificata has 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 5 Pending investigation 1 Netural e Hospital or Attanding 124 hours after death. e Funeral Director: Afte 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steled.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steled. 29e. Certifier completaly (Check only one) within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 118 North SI Suite 3B,

State Registrar

31. Dete filed (Month, Dey, Year) SEP 1 0 1998

32. Registrer's Signature

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The Maryland

filed within 72 hours after

The law requires that the death certificate be executed

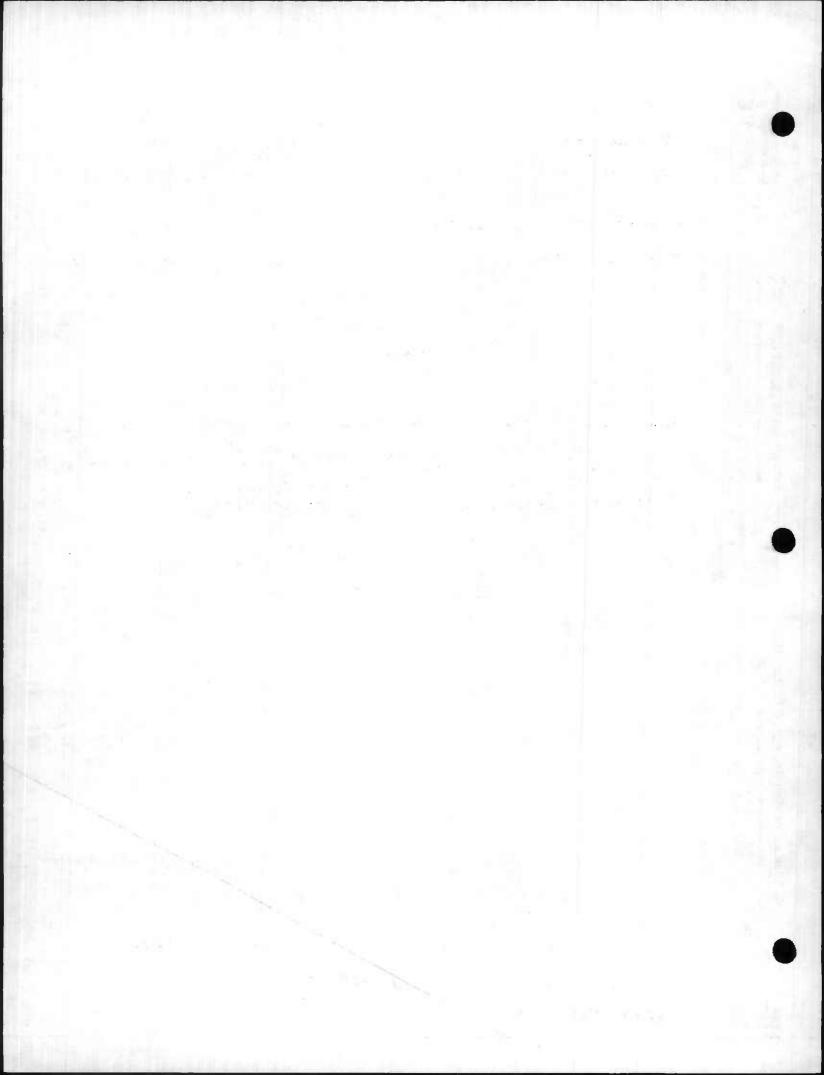
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P.O.

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Division of Vital or Attanding Physician:

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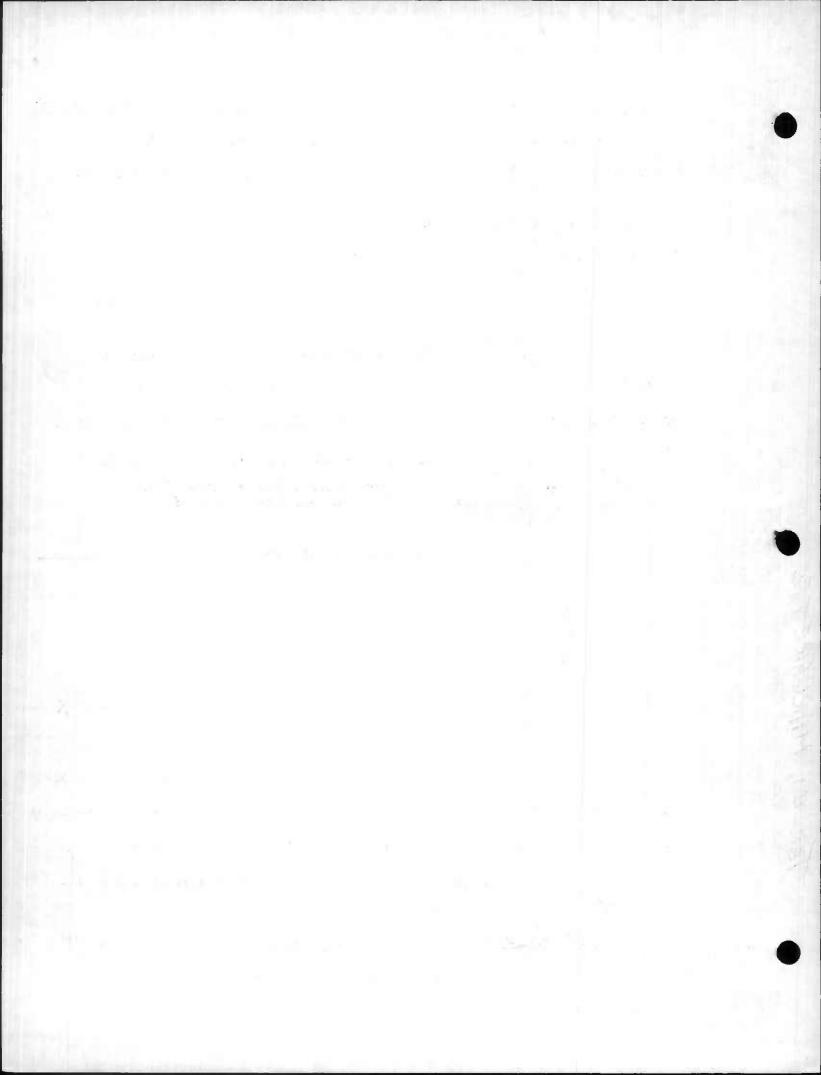


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sonth **Physician** Tenly Marquerite Ursula eptember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 600 Block Bainbridge Road Port Deposit Cecil 5. Social Security Number If Under 24 Hrs. Hours Min. If Under 1 Year 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF 215-20-5875 72 Yrs. Director 1926 Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow na 23a or 28a-f ahor 1 Yes 2000 Director Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 Lynn Lee Drive 21001 U.S.A. Funeral 7 is marked other than "natural", or items i traumatic event, the Medical Examiner ma 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2₺ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Cardiac Care, ICU 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 end 2 should be fill iment of Health and Mental Hitant: If Item 27 is marked oth Be Asa Martz Regina Marie Billings 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If Item 27 is any injury or other traconce. Mark J. Tenly (Son) 3116 Aldino Road, Churchville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 9/12/98 Aberdeen, Maryland 21. Signature of Fugeral Service Licenses 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3:

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aberdeen, Maryland 21001-3399 Interval Between Onset and Death **Physician** records /Medical Immediate Cause (Final Multiple tauma MINUTES disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s certificata has been signed by director, page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to Completed 24a. Was en eutopsy completion of cause of death? certificeta has 2 No Be 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) WQNWCLY Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 res 2 No 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? or Attending 5 Pending Investigation Injury 1 Natural 1 Yes 2 No 916198 2030 PM 2 Accident Cour accedent To the Hospital or Attend within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Mahmay 600 Hack Bounbridge Rd 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(a) and manner stated. Medical 29a. Certifier 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 918 (98 (September) m051035 10 30. Name and address of person who sempleted ceuse of deeth (Item 23a) (Type, Print) Union Hospital s. or tega wo EILCHON MD 31. Date filed (Month, Dey, Year) 37 Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 2 9 4 2 5 Certificate of Death

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2011 1 1 447

State of Maryland / Department of Health and Mental Hygiene 98 29426

						Cei	rtificat	e of	Death		R	eg. No.		
		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea			3. Time of Death
Physicia	_	DANIEL L	arm ar	משמנו							Month SEPTEMB	Day	Yeer 1998	0004AM
/Medic		4a Facility Name (If no			herl				4h City To		cation of Deeth	4c. County		_0004AM
Examin	er	4a Facility Name (II II	ot manunon, giv	e sireet and num	001)				40. Oily, 10	, or Ec	ognon or boom	AC. COUNTY	y or Death	
		PRINCE GEX					1 Williams	1 1/2 22	CHEVE				CE GEX	
Funeral		5. Sociel Security Num		Sex 7	. Age (In yrs. la		If Under Months			Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (Stete or Foreign try)
Director		212-15-6	168	AJM ZUF	26	Yrs.					4/9/72		Mary	
2	-	Usual Residence of De			1	_								
anylar show		10a. State 1	0b. County		10c. City	, Town or Lo	ocation						1	Od. Inside City Limits
M H	io	MD	Cal	vert	Du	nkirk								XXYes 2 No
# E 5	Director	10e. Street and Number	er				10f. Zip	Code			1	0g. Citizen of	What Coun	try?
5-0020 72 hours after death with the Maryland natural", or items 23s or 28s-f show pical Experiment per notified as		1001 Dw	ialshou	ao Doná			20	75	1 051	5		TICA		
eath 2	Funeral	1801 Br	reknou	12. Was Deced		13			4-051		ocify Yes or No-	USA 14. Ba	ce - Americ	an Indien.
er d	5		O Marriad	Armed Ford	es?		If Yes, spe	cify Cub	an, Mexicar	n, Puerto	Rican, etc.)		ck, White,	
S at s	by F	Nover Married 3 ☐ Widowed 4 [1 ☐ Yes X			1 🗆 Yes	2 X) No	Specify:			Specil	y:	
21215-0020 d within 72 hours at glene. or than "natural", or	9			Yeer or Dat	es:								-	ite
ING 21215-C be filed within 72 h tal Hygiene. d other than "nature.	Completed		 Decedent's Education only highest gra 			16a. Dece (Give	kind of wo	rk done	during mos	t of worki	ing	16b. Kind of B	iusiness/inc	lustry
within within then then then then then then then the	g	Elementary/Second	ery (0-12)	College (1-	4or 5+)	life.	DO NOT u	se retire	id)					
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e filed al Hygie other	Be	17. Fether's Name (Fit	rst, Middle, Last,)			13		18. Moth	er's Name	(First, Middle,	Maiden Sumai	me)	
	0	Donald L	. Then	rer					Re	ttv	Jean A	shlev		
Maryla 42 should h and Men 7 is marke traumatic		19a. Informant's Name				19b. Mailii	ng Address	s (Stree			A Route Number	-		Code)
Md 2: alth ar trau		Donald T				1001	Dada	-lala	-	D = = .	J D 1	-41-	MD 2	0754
s 1 and 2 f Health item 27 other tri	-	20a. Method of Dispos		/lather		ace of Dispo			Juse_	Road	d, Dunl	20c. Location		
0 80 = 1		1 X Burial 2 (Removal from S	0.0	metery, crei	matory or o	other pla	ica)		Duto	200. EUGHION	Oily of 10	wii, Olata
altim nit. Par autmen ortant: Injury		4 Donation 5				Mem.	Gar	der	ns	9,	/14/98	Dunk	irk,	MD
Baltimore, permit. Pages 1 ar Department of Hea Important: If item; any Injury or other		21. Signature of Fune	ral Servica Licer	nsee		22	2. Name ar	nd Addr	ess of Facili	ty			4 77	
D S S S S S S S S S S S S S S S S S S S		Ma	1 , 1	KIP.	1					-		- 1.21		me, P.A.
	-	23a Part1 Filter the	disease or com	plications that cal	ged the death	Do not ent	O. E	SOX	121,	Du1	nkirk,	MD 20	1754	Approximate
		23a. Pert1. Enter the shock, or heart f	ailure. List only	one cause on ea	ch line.	. 50 1101 0111		,			. , , , , , , , , , , , , , , , , , , ,			Interval Between Onset and Death
Physician														01100(2110 200011
/Medical Examiner		tmmediate Ceuse (Fir disease or condition	nal	. 14	ead	injur	irc							
·		resulting in death)		G .		as a consec		:						
	ne.													
petn p	Examiner	Conventially tist condi	diana C	b	Due to (or	as a consec	nuence of):							
n an all-tr	EX	Sequentially list condi- if any, leading to imme	ediate		500 10 (0)	40 4 00,100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
Gox 68/60, death certificate be executed e attending physician and of for use as the bunial-transit		cause. Enter Underly Cause (Diseese or Injuthat Initiated events	ury	C										
phy s the	edlcai	resulting in deeth) Les	st		Due to (or	es e consec	quence ot):							
X entif	2			d										
Both ce attend I for us	Physician													
e de	Sic	Part II. Other significa	int conditions o	ontributing to dea	th but not resu	lting In the u	nderlying (cause gi	iven in Part	l.	23b. Did to	obacco uae co	ontribute to	the cause of death?
that the de detached	چ۱										1 D	es 28 No	3 Prol	pebly 4 Unknow
C X D	by													
2 1 2 2											24a. Was a		24b. W	ere eutopsy findings allable prior to
been shoul	et										perfor	medr	CO	mpletion of cause death?
e law has b	Completed													
= F # &	ပ္ပ										1,27 Y	es 2 No	1.2	oYes 2□ No
VICAL IN sician: The certificate irector, pag	Be	25. Was case referred examiner?	to medical						26. Plec	e of Deat	n (Check only or	ne)		
	9	1[XYes 2□ No		Hospital: 1 🗆 In	patient 2 🖾 I	ER/Outpatier	nt 3 D	OA OI	her: 4 N	ursing Ho	me 5 Resid	ence 6 🗆 Ot	her (Specif	y)
Phys eral di		27. Menner of Death		28a. Dete of (Month	Injury	28b. Time o	1 :	28c. Inju	iry at		28d. Describe h	ow Injury occu	rred	
Attending or death. ector: After by the funer	Certification:	1 Netural 2 Accident	5 Pending Investigation			Foun	d M		Yes 2	No	44			+
LIVISION If or Attending stater death. I Director: After d in by the fune	Ca		6 Could not b	9 200 Place	-98 Injury - At hor	me farm str	pet factor	v office			MOTONC	treet end Num	ber or Rura	I Route Number.
Oire or A	Ē	4 Homloide	determined	building	g, etc. (Specify,)		,,						House Number .
ital rail led					Stre						Calvert			
To the Hospital or within 24 hours afte To the Funeral Dir.	edical	(Check only 2)	□ Certifying Ph □ Medical Exar	ysician: To the b	est of my know is of examineti	/ledge, deatl on end/or in	n occurred vestigation	et the t	ime, dete er opinion, dea	nd placa, ath occurr	and due to the d ed at the time, d	ause(s) and m lete and plece	enner as s , and due to	ated. the cause(s)
the the plant of t		one)		and manne										
with To t	2	29b. Signature and titl	e of certifier				29	c. Licen	se number			29d. Date sign	ed (Month,	Day, Year)
		11	111	1 1/1	and	5 11	0	0.0	.M.E			SEPTEM	BER 1	1, 1998
	-	30. Name and address	s of person who	completed cause	of death /Item	23a) (Tuna		J.C						-, -,,,
15								C+	root	Dal4	-imo	Marria	nd 21	201
400		Stepher 31. Date filed (Month,		Raden	distrar's Signat		reili	וסנ	LeeL,	Dall	imore,	Haryta	IIU 21.	COT
Stat		or. Date med (MONIN,			gistrar's Signat		14	1	200	,				
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For a conflict, we then some as following a probability of

	11	Decedent's Name (First, Middle, Las	t)		C	ertifica	ie of	Dealli	2. Dete of D	Reg. No.		3. Time of Deeth
ysicia Nedica	_	LONNIE IRVIN TYL							Month 9	Day -	Year 9	5:261
amine	_	4e. Fecility Neme (If not Institution, give	street and numb	er)				4b. City, Town, or	Location of Dee	th 4c. County	of Deeth	
		DOCTORS HOSPITAL						LANHAM		P.G.	COUNT	Y
eral	- 1	5. Social Security Number 6. Se	3x 7. XIM 2□F	Age (In yrs.		Months	er 1 Year Deys	If Under 24 Hrs Hours Min.		rth		ace (State or Forei
ctor		0/8-38-2204	201	53	Yrs.		<u></u>			1,1945		INGTON D
		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or	Location					10	Od. Inside City Limit
	ŏ					TON DO	3					1√√ Yes 2 □ N
	ect	10e. Street and Number					ip Code			10g. Citizen of	Albeit Cours	
		3308 4th ST S.E.										
	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U	J.S. 10	-	20032 edent of F		Specify Yes or N	UNITED	STATE e- America	
	F	1 Never Merried 2 Merried	Armed Force	s?		If Yes, sp	ecity Cub	lispenic Origin? (S en, Mexican, Puer	to Rican, etc.)	Ble	ck, White, e	
	by	3 Widowed 4 Divorcad	If Yes, Give Yeer or Date			1 🗆 Yes	XX No	Specify:		Specify	BLAC	SK.
	Completed	15. Decedent's Ed	ucation		16e. Dec	cedent's Us	uel Occup	petion	de in a	16b. Kind of B	usiness/Ind	ustry
1	ple	(Specify only highest gred Elementary/Secondery (0-12)	College (1-4	or 5+)				during most of word)	rking			
	5	12	``		PLAS	STERER	{			CONSTU	CTION	
	Be	17. Fether's Neme (First, Middle, Last)						18. Mother's Nar	me (First, Middle	e, Maiden Sumen	ne)	
	2	CLYDE TYLER			,			LUCY W	ILLIAMS			
		19e. Informant's Name/Reletionship (T						end Number or Re				Code)
		GLORIA TYLER/ WIF	<u> </u>	1				S.E. WA				
		20e. Method of Disposition	Removal from Ste		Plece of Dis cemetery, c	position (Ne remetory or	other ple	ce)	Date	20c. Location -	City or To	wn, Stete
		4 Denetion 5 Other (Specify,)	I	HARMON	NY MEM	ORIA	L PARK	9-9-98	LANDOV	ER.MD	
- SAIDS		21. Signature of Funeral Service Chang	100			22. Name a	and Addre	ss of Fecility	ODE BUS			
R		PULLOX D TOO	911	M83	3 5			ER S. OPO				71.7
		23a. Part1. Enter the diseese, or comp shock, or heart failure. List only	liceums that caus	sed the deat	th. Do not e	enter the mo	de of dyle	ng, such es cerdia	c or respiratory	errest	MD_20	Approximete Intervel Between
n				- 11	1.						- 1	Onset end Deeth
l r		Immediate Cause (Finel disease or condition		ehli	1 Ca	omi	9					days
		resulting In death)	0.	gue to (c	or as a cons	sequence of):					1
1	Examiner		b	,							- 1	
	XBr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	M	Dung	of agragions	equence of	M	. 1				26-0
ŀ	19	cause. Enter Underlying Cause (Disease or injury that initiated events	. ///	ulle	ble	- (14	eloma	7 *			years
	edical	resulting in death) Last		Due to 6	ir as a cons	equence b()	1					/
1	Physician/M		d									
1	e lo	Part II. Other significant conditions co	ntribution to deal	but not me	ultina in the	undedices	eauen eil	one in Part I	995 Did	tabacca uma co	etribute to	the cause of deet
	hys	Part II. Other argumeant continuous co	ninouting to deals	Out not res	Military an area	undenying	cause gn	en in Part.		Yes #U No		ably 4 Unkno
	by P								1	700	9 L 100	and 40 min
									24a. Wa	an autopsy	24b. We	re autopsy findings ilable prior to
1	Completed								pen	ormed?	con	npletion of cause leath?
	E								10	Yes all No	10	Yes 2□ No
		25. Was case referred to medical						26. Place of Dec			_	0.00
	ToB	examiner?	Hospital: 1 SSInpr	atient 2	ER/Outpat	ient 3 D	OA OR	ine:		idence 6 🗆 Oth	er (Specify	9
		27. Manner of Death	28a. Date of b	111111111111111111111111111111111111111	28b. Time Injury	of	28c. Injur Wor		gent between the territories and	how injury occur	palantal attendant to the	
3	atio	Natural 5 Pending 2 Accident Investigation	(monay,		angur,	м		Yes 2□No				
400	tito	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building.	Injury - At hi	ome, farm,	street, facto	ry, affice		28f. Location	(Street end Numb	er or Rurai	Route Number,
1	Certification:			Today.	**				J., 5, 10	,		
	edical	29a Certifier Cartifying Phy	alcian: To the be	st of my kno	wiedge, de	ath occurred	d et the tir	me, dete end place	e, end due to the	cause(s) end me	enner es st	eted.
13		2 Madical Exami	and manner	statuc	MOII BIIDOF	-	-		IN BU BI INB IIMB	, date end place,	ariu due to	ule Cause(s)
	2	25b. Signature and title of certifier	-~	1		25	C Licens	e number	4 1	29d. Date signe		Dey, Year)
	0 1	ma	11				12	8920	17amplan	1 9.	-7-1	1998
	4											
		Name and address of person who a	empleted bytes o	deeth (Iten	n 23e) (Typ	e, Print)		11	10	1 6	Po. 1	of MI
	1	Name and address of person who as SURINDER 31. Dete filed (Month, Dey, Year)	September 1	deeth (Iten	n 23e) (Typ	9, Print)	9A	Hanov.	er Park	Firay.	cent	elf M

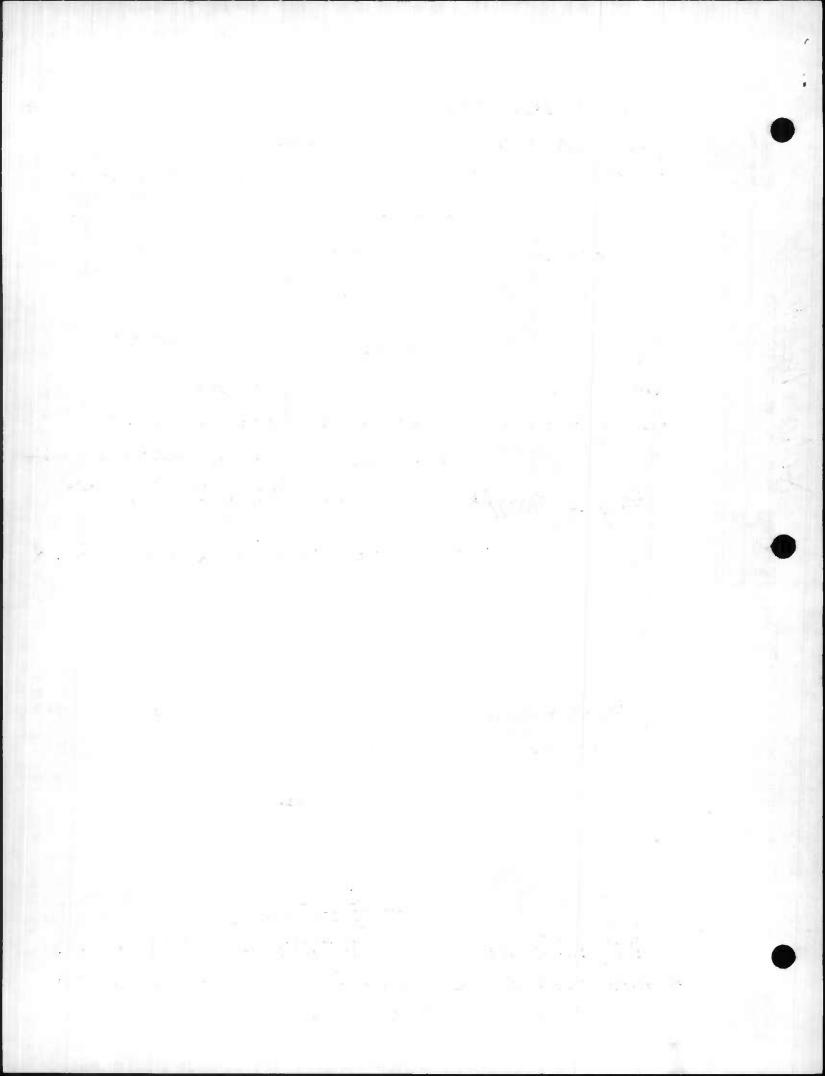
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ysician		Decedent's Name	(First, Middle, L	est)	TRE	4-1					2. Date of De Month SEP	eth Dey	199 S	3. Time	of Deeth
Medical aminer	40	Fscility Neme (If n	not institution, g	ive street end nu		3 (4	b. City, To	wn, or Lo	cation of Deet		unty of Desth	0	. (/
anniner		Gilchrest						В	altim	ore					
neral		Social Security Nur		Sex	7. Age (In yrs.	lest birthday,	If Under Months	1 Yeer Days	If Under	24 Hrs. Min.	8. Dete of Bir (Month, De	th v Year)	9. Birth	olece (Stet	e or Fore
ctor	-	12 07 075		№ M 2 F	82	Yrs.	WORKIS	Days	Tiours	IVIII 1.	Nov. 2			higar	
		uel Residence of D a. Stete	Decedent 10b. County		10c. C	ity, Town or L	ocation					•		IOd. Inside	City Lim
a de		Md.	,			ltimor							- 1		es 2 🗆 l
Examiner must be notified at by Funeral Director	106	e. Street end Numb	ber				10f. Zip	Code				10g. Citizen	of What Cou	ntry?	
io io		9112	Smith A	Ave.			21	236					USA		
ner	11.	Marital Status			edent Ever in U	J,S. 13.	Wes Deced	dent of Hi	spenic Orl	gin? (Spe	ecify Yes or No Rican, etc.)	- 14.	Rece - Ameri Bleck, White,		
F		1 Never Married	d 2 Married		2√∑No ive		1 Yes 2		Specify:	1, 1 00110	riioari, etc.,		The state of the s		
d by		3 □ Widowed 4		Year or D	Dates:								441 17		
Completed		(Specify	 Decedent's I y only highest g 	Education rade completed)		16e. Dece	dent's Usue kind of wor DO NOT us	el Occupe	etion du <i>ring m</i> osi	t of worki	ing		of Business/Ir	dustry	
d mo		Elementary/Second	dary (0-12)	College (1-4or 5+)		atche		,			Lumb	er Co.		
Be	17.	Fether's Name (Fi	irst, Middle, Las	et)					18. Mothe	r's Name	(First, Middle	Maiden Sur	meme)		
ToB	I	Harry Ea	arl Trea	at					Mir	nerva	a Henni	gan			
To Be C		a. Informent's Nam	ne/Relationship	(Type, Print)		19b. Mall	ing Address	(Street	end Numbe	or Run	el Route Numb	er, City or To	wn, Stete, Zi	Code)	
	I	Pauline F	R. Treat	(wife	e)					altir	more, M				
5	208	a. Method of Dispo		☐Removal from	State 20b.	Place of Disp cemetery, cre	osition (Nen metory or o	ne of other piec	e)		Dete	20c. Locati	on - City or T	le, M	D,
		4 Donetion 5				. Viev	7 Ceme	etery	7	9,	/6/98	Marric	ttsvil	ie, i	4d.
9000	21.	. Signature of Fune	erel Service Lice	ensee		2	2. Name en	nd Addres	s of Fecilit	y Haidh	nt Fune	ral Ho	ome & C	hape.	L
a		Hazz	y W.	Haya	62		.O.Bo	x 19	5 Syl	cesv:	ille, M	d. 217	784		
	23	a Part 1 Enter the	COOCO OF COL												
		shock, or heart	milure. List onl	y one caust on	caused the dee each line.	th. Do not en	ter the mod	de of dyln			or respiratory a		1	Approxin	nete Between Id Deeth
ian cal					A A -				g, such as	cardiac	or respiratory a	rrest,		Approxin interval E Onset er	Between
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DHMH 16 Rev 6/95



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ant: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Spec		Sacred I	Heart Cem	etery	9/12/98	Port V		
Important: If it any injury or once.		21. Signature of Funeral Servica Lice	Haighta.		.O. Box 1	н	aight Fun ville, MD		ome &	Chapel
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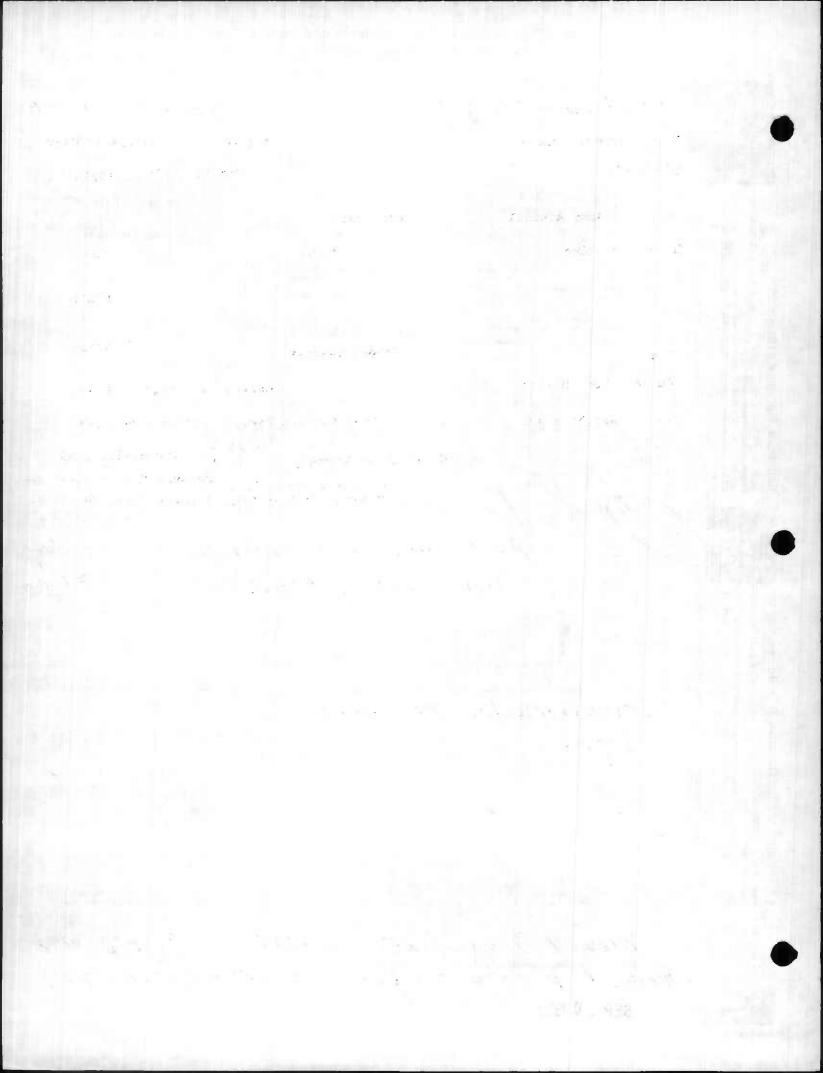
State of Maryland / Department of Health and Mental Hygiene 9 8 29 43 0 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3 Time of Death oustance is Soptember 08 Yeeps **Physician** Wright 10:24 Aug /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore Baltimore City If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F 229-20-5495 Yrs. 71 Director Dec 11, 1926 Virginia Usual Residence of Decadent 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Severna Park Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Sunset DRive 21146 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: þ White 3 Nidowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education School Teacher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and 2 should be Aubrey Lee Miller Martha Washington Kahn 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) It. Pages 1 and 2 intment of Health a prient; if frem 27 is 516 West College Ave., Salisbury, MD 21801 Dion P. Wright - son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 11 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremetion 3 Removal from State Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 1998 21. Signature of Funeral Service Line 22. Name and Address of Facility Severna Park Funeral Home Barranco & Sons, P.A. 495 Gov. Ritchie Hwy., Severna Park, enter the mode of dying, such as cardiac or respiretory arrest. 21146 disease (or sompli failure. List only or Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition sesulting in death) /Medical Acute myocardial Infarction Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): å Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? Cerebrovascular 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 8 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 88 28. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To Pris 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending after death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital M hours of 24 hours of Furneral 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) To the Your Young 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number Marca Muynul N 30. Name and address of person who completed the original state of the

Registrar

31. Date filed (Month, Day, Year) SEP 1 0 1998

32 Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** September 4,1998 3:23 AM MARGARET C. WRIGHT /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot if Under 1 Yeer if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) 5. Sociel Sacurity Number Birthplace (Stata or Foreign Country) **Funeral** 1 M 2 X F **Director** 219-30-2902 63 NOV. 9 1934 MARYLAND Usual Residenca of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mail cal Examinar must be notified at 1 Yes 2 □ No Director MARYLAND QUEEN ANNE CHESTER 10f. Zip Code 10g. Citizen of What Country? Funeral 2 1 6 1 9

13. Wes Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 105 WRIGHTS ROAD deeth U.S. 14. Race - American Indian. 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 🛣No Specify: Specify: py 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 10th HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ABE CROMWELL ETTA HAYES and I 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pagas 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun page. 105 WRIGHTS RD. CHESTER, MD. 21619 ANDREW WRIGHT (HUSBAND) 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Surial 2 Cramation 3 Removal from Steta 9/9/98 CHESTER, MD. UNION WESLEY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. WEST ST. ANNAPOLIS, MD. 21401 Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting In death) umone Examiner Examiner Neu physicien and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in daath) Lest certificate be exec elastatie Physician/Medical 980 10 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? the signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed peeu has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Daath (Check only one) 1 Yes 2 No Othar: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After Natural 5 Panding after death. Director: Aft 1 Yes 2 No Investigation 2 Accident 6 Could not be detarmined 3 Suicide 28f. Localion (Street end Number or Rural Route Number, City or Town, Stata) 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifiar edicai (Check only one) To the I within 2 29b. Signature and title of cartified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IDLEWILD

32. Registrer's Signature

DSAHIELD 509

SEP 0 9 1998

31. Date filed (Month, Day, Year)

AVE.

EASTON, MD.

21601

State Registrar

Maryland 21215-0020

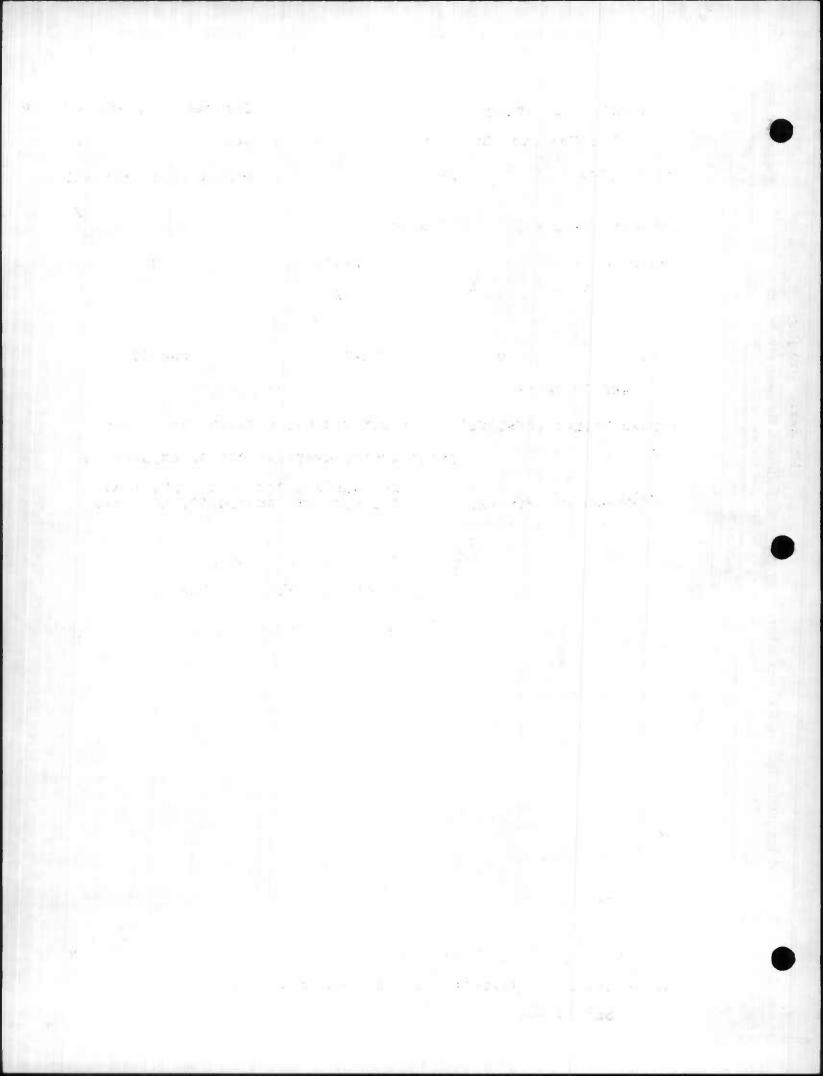
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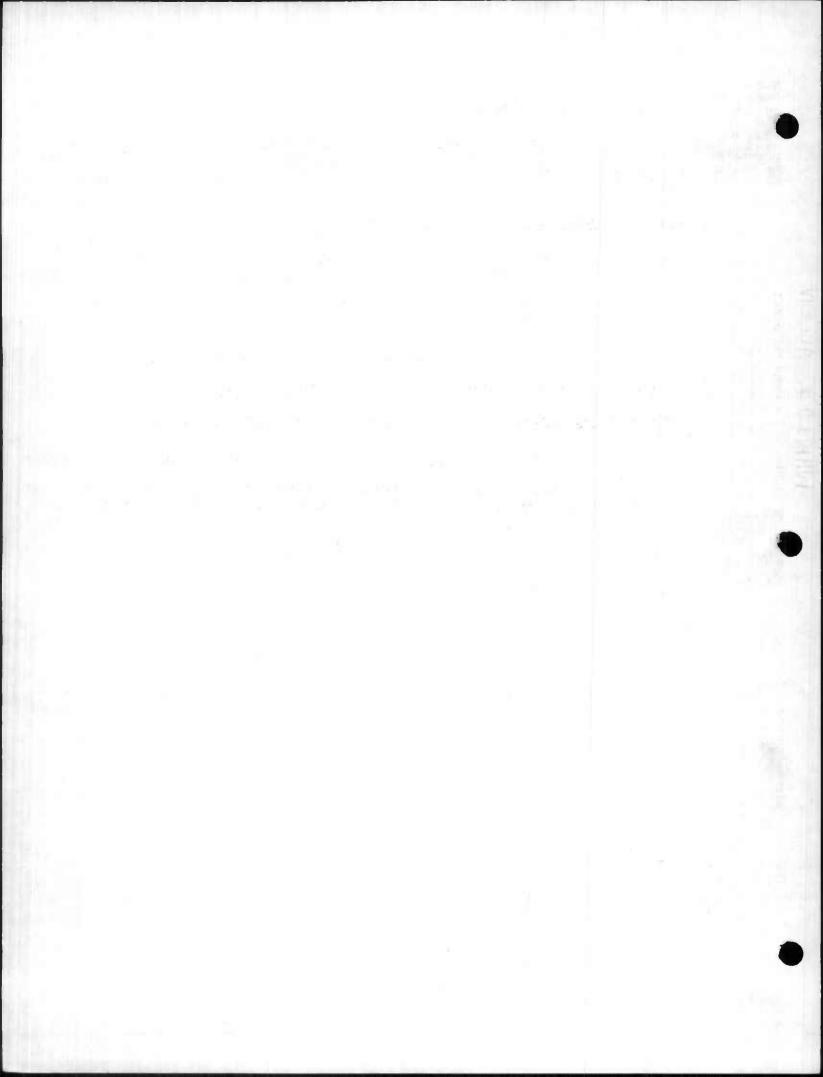
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Division of Vital Records,

Margaret Wrighr



		State	of Maryland /	Department of I	Health and Ment Death	al Hygiene (38 29432
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	עשלים א	4 Donetion 5 Other (Specify) 21. Signature of Funant Service Licensee	Seavi	.11e Cemeter		1-98 Seav.	ille, New Jersey
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0 5027	20a. Method of Di 1 2 Burial 2	sposition Comparison 3	Removal from Sta	0.000	e of Disposition (Na etery, crematory or o	me or other pla	ce)	Date	20c. Location	- City or Town,	, State	
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To the Hospital or within 24 hours sit completely filled in Medical Cert	29a. Certifier (Check only one)	© Certifying Pt 2 Medical Exa	nysician: To the bes miner: On the basis and manner	of examinetion	dge, death occurred and/or investigation	at the tir	me, date and place, opinion, death occur	and due to the red at the time	cause(s) and m , date end place,	anner as state and due to the	id. e cause(s)	
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	30. Name and add	lress of person who		death (Item 23	(Type, Print)	1:	E 11 -	3	D og con	m-1/2	1117	
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State Registrar	5	EP 1 1 19	98	7	P. 14	ack	2					

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

111 Penn Street, Baltimore, Maryland 21201

3. Time of Death

	1. Decedent's Name (First, Middle, Last)
Physician /Medical	KATHERINE MILI
Examiner	4a Facility Name (If not institution, give s
	SOUTHERN MARYLAND H

Month SEPTEMBER 10, KATHERINE MILDRED WARD 1998 0658AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death SOUTHERN MARYLAND HOSPITAL CENTER E.R. CLINTON PRINCE GEORGES If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 9. Birthplace (State or Foreign 5. Sociai Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2\ F Months Days Hours Yrs. 214-28-2585 66 FEBRUARY 23, 1932 MARYLAND **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinat must be never some. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo MARYLAND PRINCE GEORGE'S BRANDYWINE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15501 LETCHER ROAD EAST 20613 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: p 3 ☐ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN ASMUSSEN NETTIE CURTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT EUGENE BOSWELL - SON 15801 LETCHER ROAD EAST, BRANDYWINE, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date XBurian 2 Cremation 3 Removal from State S □ Other (Specify) 4 Dogation RESURRECTION CEMETERY, SEPT. 14, 1998, CLINTON, MD 21. Signalure of Fulleral Survey Low MGB 22. Name and Address of Facility
THE HUNTT FUNERAL HOME, INC. stran MARK G. BROHAWN M00053 P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner and I-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): physician at s the buriel-t Physiclan/Medical Due to (or as a consequence of): 88 for use as signed by the a 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Division of Vital Records, P. p 24b. Were autopsy findings available prior to been si 24a. Was an autopsy performed? Completed completion of ceuse of death? certificate has b etes 2 | No 2 No Attending Physician: director, 25. Was cese referred to medicel examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1⊠ Yes 2 No 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending Investigation Natural 1 Yes 2 No death. 2 Accident or Attendation after deat 6 Could not be determined To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a, Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 10, 1998 no O.C.M.E. 30. Name and address of person who completed cluse of death (Item 23a) (Type, Print)

Registrar DHMH 16 Rsv 6/95

State

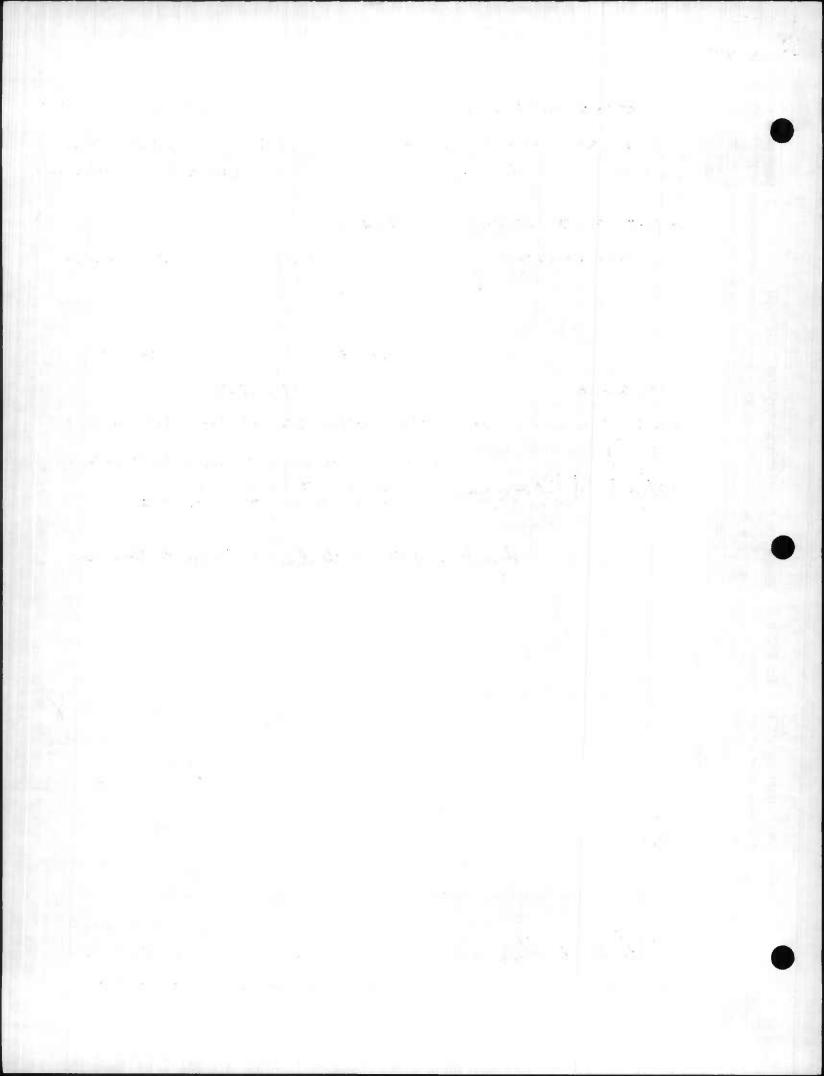
31. Date filed (Month, Day, Year)

SEP

15

1998

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 2:20 pm Jean Carol Windsor September 10, 1998 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)

Months Deys Hours Min. Dec. 12, 1936 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Vrs Director 61 577-50-3157 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Introportant: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any Injury or other treumstic event, the Medical Examiner must be nextranspace. 10e Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits Maryland Chesapeake Beach Calvert 1 Yes 2□ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3911 28th Street 20732 USA 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American indien, Bleck, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementery/Secondary (0-12) school bus driver board of education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John Henry Curtin Rosa Davis 19a. Informant'a Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Benjamin F. Windsor / husband same as # 10 above 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from Stete Resurrection Cemetery 9-14-98 4 ☐ Donetion 5 ☐ Other (Specify) Clinton, MD 21. Signature of Funerel Service Licensee 22. Name end Address of Facility William & Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each lina. Approximate Intervel Between Onset end Death **Physician** /Medical immediate Cause (Final PROBABLE RENTH CELL CA WITH METASTASIS diseesa or condition resulting in deeth) Examiner Examiner sician end burial-transit that the death certificete be executed Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): physician s the burial P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CVA WITHRIGHT HEMIPARESIS Records, þ cate hes been sig, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Piece of Deeth (Check only ona) 1 Yes 2 No Hospitei: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 After this funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. injury at Work? 28d. Describe how fnjury occurred Certification: Attending 5 Pending death. To the Hospital or Attendition within 24 hours effer death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigetion 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and pleca, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the tima, dete end place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50963 30. Name and eddress of person who completed causa of deeth (item 23a) (Type, Print) 18 WITON LUKBAN, MD, 135 W. DARES BEACHED, PRINCE FREDERICK, MD 20678 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State

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Registrar

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State of Maryland / Department of Health and Mental Hygiene

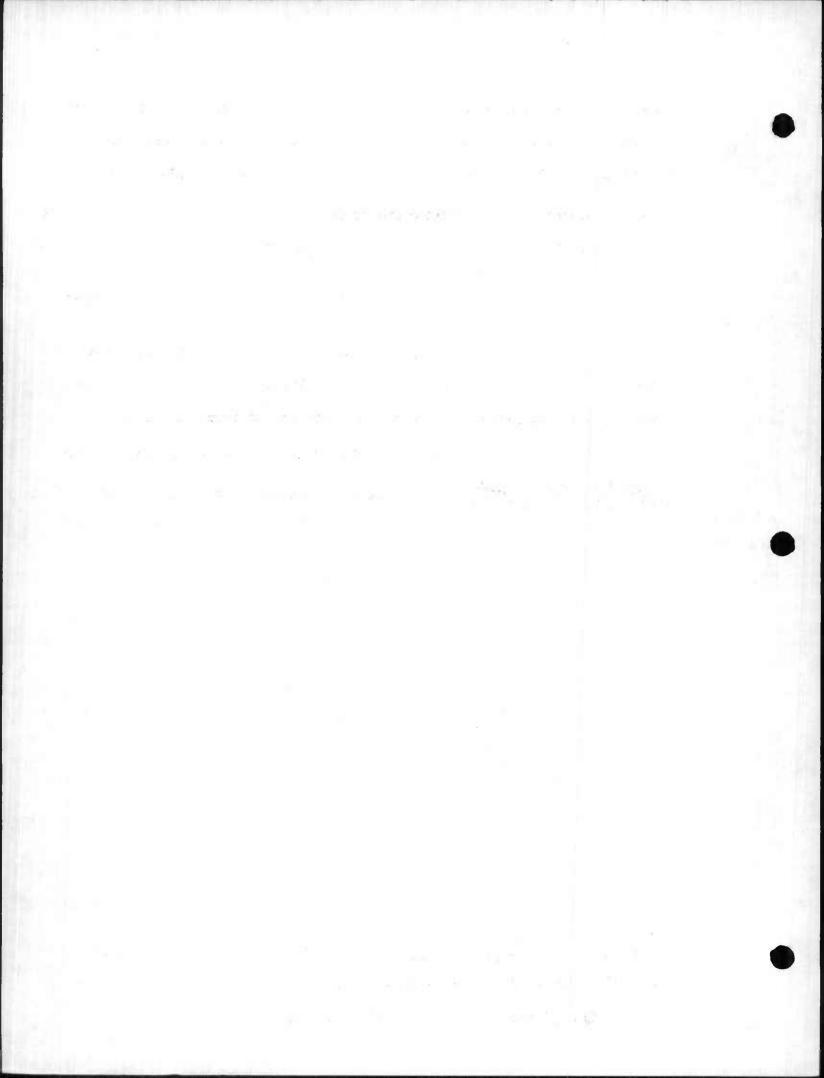
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	th with th	Funeral Director	10e. Street and Number 475 Wilson Road			10f	Zip Coda 206	39			I 0g. Citizan of V USA	Vhat Coun	try?		
020	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23s or 28s-f show ent, the Medical Exercise must be recitied at	by Funer	11. Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedani I Armed Forces? 1 Yes 2 N If Yes, Give Yaer or Datas:				Hispanic Ori ban, Maxican Specify:		scify Yes or No- Rican, etc.)	14. Race Biac Specify	e - Amarico k, White, e Bla	etc.		
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Baltimore,	permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr otice.		20a. Mathod of Disposition 1 ABurlal 2 □ Cramation 3 □ 4 □ Donetlon 5 □ Other (Specify		20b. Plece of comatary	, crematory	or other pl		9,	wn, Stete					
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State of Maryland / Department of Health and Mental Hygiene

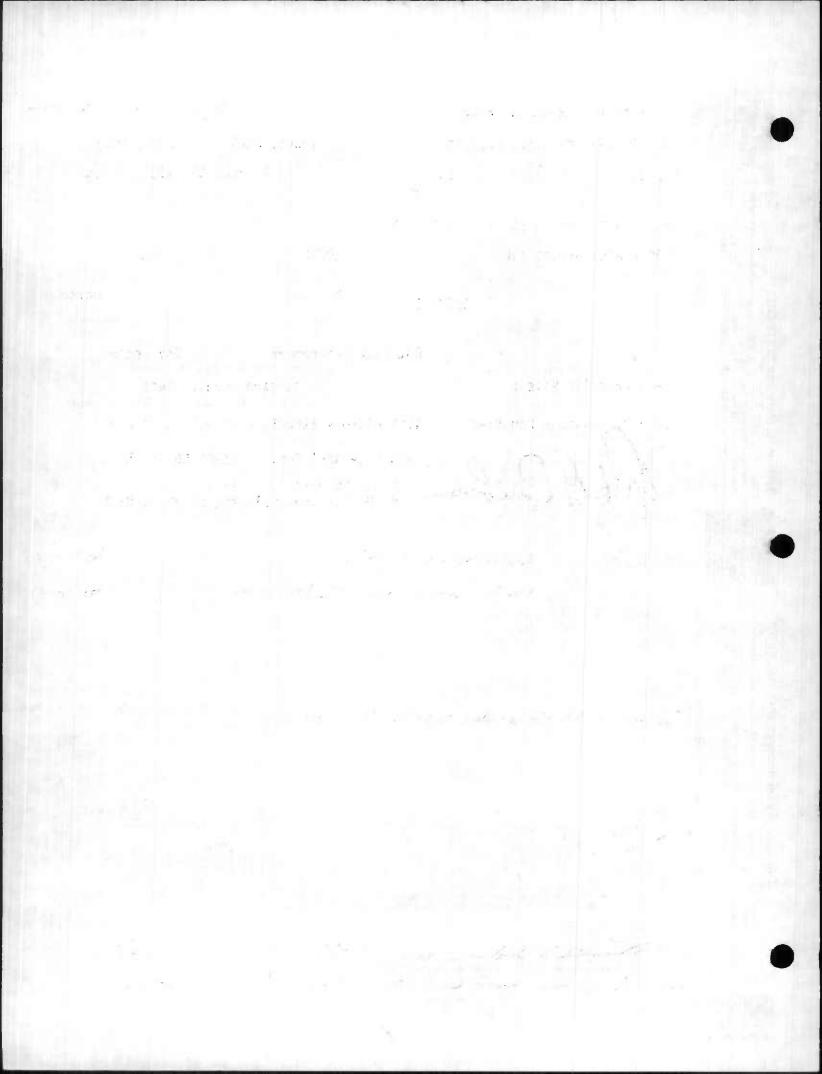
Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death **Physician** Month Jacob Karol Wildstein September 8, 1998 1600 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince 1. 8. Data of Birth (Month, Day, Yei May 17, 1 Calvert Memorial Hospital Calvert 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country)
 MD **Funeral** 10 M 20 F 94 Yrs. 220 09 4168 Director Usual Rasidance of Decedant the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Calvert Prince Frederick Director 1 ☐ Yas 2 No 10e. Sfreet and Number 10f. Zin Code 10g. Citizan of What Country? ŏ 85 Duke Street 20678 USA "natural", or items 23a deeth y Funeral 12. Was Decedanf Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian, permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Heelth and Mentel Hygiene. Important: If item 27 is merked other than "natural"——any injury or other traumetic available. Black, Whita, atc. 1 Navar Marriad 2 Marriad 1 Yas 2 No If Yas, Giva Yaar or Datas: white 1 Yas 2 XNo Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona duning most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) proprietor retail sales 17. Fathar's Nama (First, Middla, Last) 18. Mofhar's Nama (First, Middla, Maldan Sumama) Be Louis Wildstein Rebecca unknown 19a. Informanf's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) PO Box 355, Prince Frederick, MD 20678 Marie E. Wildstein/wife 20b. Placa of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Emmanuel UM Church Cem. 9-11-98 Huntingtown, MD 4 Donation 5 Other (Specify) 22. Nama and Addrass of Facility Rausch Funeral Home, Owings, MD 20736 Pert1. Enter the disease, or complications that she shock, or heart failure. List only ona cause of each death. Do not enter the mode of dying, such as cardiac or respiratory arrasf, Approximata Interval Between Onset and Death Physician /Medical Immediate Causa (Fina DNEMMONIA disaasa or condition rasulting in daath) IWK Examiner Due to (or as a consaquanca of): Examiner that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thaf initiated events resulting in death) Last -tran and Dua to (or as a consequence of) physicien at s the burief-I P.O. Box 68760, Physician/Medical the Dua to (or as a consequence of): attending p 980 Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 Trobably 4 ☐ Unknown DEHYDRATION, been signed t should be det Records. p The lew requires Be Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? SEVERE ADRIC STENOSIS page 2 ANEMIA 1 Yas 202 No certificate 1 Yas 2 No Division of Vital Hospital or Attending Physician: 24 hours efter death.
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) and manner stated. edical 29a, Certifian 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Dafa signed (Month, Day, Year) SUITELOG 30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print) FULTON LUKBAN, M.D. , 135 W. DARES BEACHED., PRINCE PRODUCK, MD 20653 31. Dafa flied (Month, Day, Year) 32. Registrar's Signatura State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Maryla		Certificate				Reg. No. 98	2943	38	
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	Funeral Director		5. Social Security Number 6. Social Security Number 1		rs. last birt	thday) If Under 1 Months Months	Year Days	If Under 24 Hrs. Hours Min.	8 Date of Bir	th	9. Birthplace (State Country) Florida	or Foreign	
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020	72 hours effer death with the Maryland natural', or items 23s or 28s-f show sicel Examination must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 1 2 Yes 2 □ No If Yes, Give Year or Datas: 195		If Yes, speci		Hispanic Origin? (S ean, Mexican, Puert Specify:	o Rican, etc.)	Specify.	k, White, etc.		
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	To the Hospital or Att within 24 hours effer of To the Funeral Direct completely filled in by	edicai C		reiclan: To the best of my liner: On the basis of examend menner stated.								e(s)	
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			30. Nama and addrass of person who	completed ceusa of death (Item 23a)			359A		.1.0	1.0		
			Omica of Caronda		1614	8.00	107	Kona Par	c'wo	90813	2		
	Stat Registra		31. Date filed (Month, Day, Year) SFP 1 6 1	32. Registrar's Si	_	B. 1	200	4)					



State of Maryland / Department of Health and Mental Hygiene

29439 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month HAROLD LYNN WILDER /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Prince George Lanham If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Yaar) If Under 1 Year 7. Age (In yrs. iest birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 15√M 2□ F 577-06-9789 Yrs. Director 67 Washington, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f showed call Examiner must be notified at 13808 Bentwaters Marlboro Drive Director 1√2 Yes 2 □ No Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13808 Bentwaters Drive 20772 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1X Never Married 2☐ Married 1 □ Yes 2○No If Yes, Giva Yeer or Dates: 1 Yas 2 No Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 7 is marked other than "natur traumatic event, the Medical 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decadent's Education (Specify only highest grede com 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Hygiane. Pastor Private 4 years 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nant of Health and Mantail Jonathan Wilder Annie E. Thompson Wilder P L 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) or other train 4910 Procopio Drive; Camp Spring, MD 20746 of Disposition (Name of Data 20c. Location - City or Town, State Jonathan Wilder (Father) 20b. Place of Disposition (Name of cemetery, cramatory or other pleca) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Washington Nat'l Cem 9/12/98 5 Other (Specify Suitland, MD. 22. Name and Addrass of Facility Robert O. Freeman Funeral Glenda reeman Svcs, Inc. 1601 Kenilworth Ave, NE WDC 20019 23a. Part1. Ental the disease, or completitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Betwoonset and D Physician /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be axecuted bunial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Box 68760. Physician/Medicai the Due to (or as a consequence of): 80 usa for P.O. signed by the a Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, ð 24b. Were eutopsy findings avelleble prior to Completed 24a. Wes en eutopsy completion of cause of death? page 2 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No of Vital Physician: diractor. 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) To 1 Yes 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftart Division or Attending 1 Naturel 2 Accident 5 Pending investigation s after death. 1 ☐ Yas 2 ☐ No 3 Sulcide 6 Could not be determined in by t 28f. Location (Street end Numbar or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homleide To the Hospital within 24 hours a To the Funeral C Hospital TSL Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certiflar Medical complataly (Check only 29b. Signature and title of certifier 29d. Date amod (nd addrass of person 32 Registrar's Signature State SEP 1 1 1998 Registrar

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State of Maryland / Department of Health and Mental Hygiene 98 291,40

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xamine		4a. Fecility Name (If not institu	tion, giv	re street end nu	imber)			4b. City, To	own, or Lo	ocation of Dee		y of Death		7111		
		Holy Cross	Hos	spital				Silv	ver S	Spring	M	ontgo	mo YII			
neral		5. Social Security Number	6. 5		7. Age (In yrs	s. last birthdey)	If Under 1 Ye		r 24 Hrs.	8. Date of B	irth			e or Foreir		
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ad at		10a. State 10b. Cou	nty		10c. C	City, Town or Lo	ocation						10d. Inside	City Limit		
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the Medical Ex			-	Year or D	etes:											
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5		19e. Informent's Name/Relation		31												
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r other		20a. Method of Disposition				Place of Dispo	sition (Neme of metory or other p	olece)		Date	20c. Location	- City or To	own, State			
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		4001 Benning Rd., N.E. Wash., D.C.											0019			
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	9 2			and man	ner stated.											
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amine	r	4e. Facility Neme (If not insti	GEOR	0-1	HOSPIT	AL CE	NTER		WERLY	- 11	CE GEO	rges		
eral ctor		5. Social Security Number 577–60–3618	6. Sex	M 20 F	. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of E Min. (Month, I April	Day Year) 26, 1908	9. Birthplece (S Country) Bomberg	Stete or Foreign		
100	- 1	Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	ty, Town or Lo	cation				10d. Ins	side City Limits		
oe notified at	CTO	D.C.	N/A		Wa	shingt	on				15	Yes 2□No		
	5	10e. Street and Number 5131 Chillum	Place	NF			10f. Zip Code	20011		10g. Citizen of U.S.				
	by Funeral	11. Marital Status 1 Never Married 2	Married 1	2. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? No		Was Decedent of f Yes, specify Cut	Hispenic Origonal, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)					
3	red	15. Dec	edent's Educi	ation	95.	16a. Deced	ient's Usual Occu	pation	of wadda	16b. Kind of B	usiness/Industry			
- I	Сощріете	(Specify only h		College (1-4	4or 5+)		kind of work done		or working		1 5			
3	2	10th 17. Father's Name (First, Mid	idle, Last)			Freva	tor Oper	T	r's Name (First, Middle			ue Servi		
	o De	William G. Wi	1son					Juli	la Daniels					
men		19a. Informant's Name/Relationship (Type, Print) Hester Hawkins - God Daughter 19b. Mailing Address (Street end Number or River) 5131 Chillum Pl. NE,												
physician and 100 20 important: if item 27 is the bunal-transit at 10 10 10 10 10 10 10 10 10 10 10 10 10		20a. Method of Disposition 1 \(\mathbb{R} \) Bunial 2 \(\mathbb{C}\) Cremation 3 \(\mathbb{R} \) Removal from State 4 \(\mathbb{D}\) Donation 5 \(\mathbb{O}\) ther (Specify)									Cify or Town, St	ate		
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's funeral												
		Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line.												
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death SEPTEMBER 5, 1998 PENE SKELICHE WATTS 8:00AM 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth PRINCE GEORGE'S 3105 TRINITY DRIVE 8. Date of Birth (Month, Dey, Year) If Under 1 Year if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthpiece (State or Foreign Country) Months Deys Hours 1□ M 2]() F Yrs. 89 MAY 15, 1909 GEORGIA 259-26-8173 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND PRINCE GEORGE'S 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zio Code 3105 TRINITY DRIVE 20715 UNITED STATES 14. Rece - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 CASHIER GROCERY STORE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) ANDREW BROWN ANNA PAPADEAS 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) MERL WATTS, HUSBAND 3105 TRINITY DRIVE, BOWIE, MARYLAND 20715 20b. Place of Disposition (Neme of cemetery, cremetery or other place) Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 9/9/98 FORT LINCOLN CEMETERY BRENTWOOD, MARYLAND 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. RD Approximete Intervel Between Onset end Death Immediate Ceuse (Final disease or condition resulting in deeth) PNEUMONIA 1 WEEK Due to (or es e consequence of): ALZHEIMER'S DISEASE 3 YEARS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as e consequence of): 23b. Did tobacco usa contributa to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed' 1 ☐ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 X Cartifying Phyercian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d, Date signed (Month, Dev. Yeer)

P.O. Box 68760,

The law requires that the death certificate be executed physicien and sthe burial-trans ettending p signed by the end to be detached for Division of Vital Records, been sign is certificate has t I director, page 2 s or Attending Physician: this After rector: Direc n 24 hour. To the H within 24 To the F

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permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at page.

Physician

/Medical

Examiner

altimore, Maryland 21215-0020

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State Registra

Kogn B

30. Name end eddress of person who completed cause of death (item 23e) (Type, Print)





D05891

SEPTEMBER 7, 1998

State of Maryland / Department of Health and Mental Hygiene

		Decedent's Nama (First, Middle, I	ast)		ertificate c	Dealli	2. Data of Death	J. No.	3. Tima of Death		
Physi-		Alvin	Henry	Weems			Month September	Day	,1998 4:56 P.M		
/Med Exam		4a. Facility Nama (If not Institution, g				4b. City, Town, or Lo		4c. County			
LAUIII	11101	Southern Mary	land Hospita	1		Clinton		Prince	e Georges		
Funera Directo		5. Sociel Security Number 6. 579–48–0894	Sex 7. Age (fin yrs. last birtho	Months Day		8. Data of Birth (Month, Day,) October	7ear 1933 29,	9. Birthpleca (State or Foreign Country) Washington, D.		
P .		Usual Rasidance of Decedant 10a. Stata 10b. County	1	Oc. City, Town o	r Location				10d. Insida City Limits		
sho of s	2								1 1 Yes 2 □ No		
he N	ect	Maryland Princ	e Georges	Tem	ple HIlls				4		
ath with t	Funeral Director	10e. Street end Number 6103 Summerhil	1 Road		10f. Zip Cod	48	i		Vhat Country? States		
27275-0020 d within 72 hours after death with the Meryland giene. If than "natural", or flems 23s or 28s-f show than "natural", or flems 28s or 28s-f show than "natural".	þ	11. Maritai Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yas 2 No If Yes, Give Year or Datas:	ar in U,S.	I3. Wes Decedent of If Yas, specify C	of Hispanic Origin? (Sp cuben, Maxican, Puerto No Specify:	ecify Yes or No- Rican, etc.)		a - American Indian, k, White, etc.		
2 ho	Completed	15. Decedent's	Education	16a. D	ecedant's Usuel Oc	cupation	16	Bb. Kind of Bu	sinass/Industry		
21215-U Iwithin 72 ho iene. than "natur the Medical	pie	(Specify only highest g		de completed) (Give kind of work of life. DO NOT use if			ing 1	D.C. G	overnment		
D D -	E	10th grade	Conaga (1-401 54)		uck Drive	er	1	Dept.o	f Public Works		
	BeC	17. Fethar's Nama (First, Middle, Las	it)			18. Mother's Name	(First, Middle, Ma	iden Sumame)			
Maryland of 2 should be file lith and Mental Hy 7 is marked other traumatic event	ToB	Charles	Henry	Weems		Elener		В	ruce		
Maryla d 2 should h and Men 7 is marke	-	19a. tnforment's Name/Ralationship	(Type, Pnint) (wife	19b. M	ailing Addrass (Stre			16b. Kind of Businass/Industry D.C. Government Dept.of Public Work Maiden Sumame) Bruce Der, City or Town, State, Zip Code) Hills, Maryland 20748 20c. Location - City or Town, Stata Brentwood, Maryland Mason Funeral Home, Washington, D.C. 20020 Derrest, Approximate Interval Batween Onset and Death			
		Alberta Barbara	(MITT	-/				_			
- F 5 5		20a. Mathod of Disposition	Trecenct wee			place) Sept.11					
Defilimore, pemit. Peges 1 as Department of Hee Important: If item; any injury or other		MBurial 2 ☐ Crametion 3 4 ☐ Donation 5 ☐ Other (Spec	ify)		Incoln Ce	metery	B	rentwo	od, Maryland		
Deparition of the part of the		21. Signature of Fuebral Service Lio	Anth	-							
		23a. Part1. Entar tha disaasa, or co shock, or haart failure. List on	mplications that caused the	e deeth. Do not	enter the mode of o	dylng, such as cardiac	or raspiratory erres	it,	Approximete		
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rificate be axecuted ng physician and es the burial-transit	Physician/Medical Examiner	Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disease or Injury that initiated evants rasulting in death) Last	c	a to (or as a con							
deeth cert deeth cert e attendin od for use	lcian/	Pert II. Other significant conditions	agatributing to doubt but a	not en quible a in th	a underhine acuse	shop in Red I	20h Bidah	ntribute to the cause of death?			
े हैं हैं	hys	reit ii. Other argrinicant conditions	contributing to death but i	tot rasulting in th	a undarrying causa	givan in Part I.					
that the det	by P						1 U Yes	2 □ No	Probably 4 Unknow		
he law requires that he has been signed b	Completed b						24a. Was an performe		24b. Wara autopsy findings aveilable prior to completion of cause of death?		
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2 00 17	To	axaminar? 1 ☐ Yas 2Ki No	Hospital:	2 ER/Outpa	tient 3 DOA	Other			ar (Specify)		
= 2 P		27. Mannar of Death 1. SNaturai 5 ☐ Panding 2 ☐ Accident invastigati	28a. Data of Injury (Month, Day Y	28b. Tim	e of 28c. In		Homa 5 ☐ Rasidanca 6 ☐ Othar (5 28d. Dascribe how tnjury occurred				
To the Hospital or Atlanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Sulcida 6 ☐ Could not 4 ☐ Homicida datarmine		- At homa, farm, Specify)	streat, factory, office	ca	28f. Location (Stre City or Town,		er or Rural Route Number,		
Hospit 24 houn Funeral letely fille	edical	29a. Cartifiar 1 Certifying F (Check only one)	hysician: To the best of miner: On the basis of ax and manner steted	amination and/o	aath occurred at tha r Invastigation, in m	tlma, data and piace, y opinion, daath occurr	and dua to the cau ed at the time, det	se(s) and ma a end plece, a	nnar as stated. and due to the cause(s)		
of this	Me	29b. Signeture and title of certifier			29c. Lice	ense number	290	d. Dete signed	d (Month, Day, Year)		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) Dete of Death EDWARD WINEMILLER 4b. City, Town, or Location of Deeth ESTMINSTER Under 24 Hrs. 8, Date of Bir If Under 1 Year Months Days 7. Age (In yrs. last birthdey) 10 M 20 F Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of Whet Country? 12. Wes Decedent Ever in U,S. Armed Porces? 1 Pes 2 □ No If Yes, Give Yeer or Detes: W W ∏ Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ECREATION - PARK 17. Fether's Neme (First, Middle, Last) URVIN MARY 19a. informant's Neme/Relationship (Type, Print) Road, Westminster MD 2/15 Dete 200. Location - City or Town, Stete Josephine Esposito, sister 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Carroll Cremations 4 ☐ Donetion 5 ☐ Other (Specify) 9.10.98 HampsTead, MD 21. Signature of Funerel Service 22. Name end Address of Facility 412 WASTINGTON PO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Immediate Ceuse (Final diseese or condition resulting in death) Corony Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Due to (or as e consequence of): 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 ☐ Unknown 24b. Were eutopsy findings evelleble prior to 24e. Wes en eutopsy

Physician /Medical **Examiner**

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21215-0020

altimore, Maryland

Physician/Medical Examiner Completed Be Certification: To

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

completion of cause of deeth?

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical 26. Plece of Deeth (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☐ No

27. Menner of Deeth 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Naturel 2 Accident 6 Could not be 3 Sulcide 4 - Homlcide

28d. Describe how injury occurred 1 Yes 2 No

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Location (Street and Number or Rurel Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29b. Signature end title of certifier Mold J. Mon

29c. License number

29d. Date signed (Month, Dey, Year) 9

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Moss

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Registrar

31. Dete filed (Month, Day, Yeer)

32. Registrer's Signeture

sa uvilin anivia aprobable JUAS THE SAME 1211 12 21 All Colorette Wilson, November FOR PERSON ED Be made but a specific men social Commence of the second The contract of the contract o

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #18 Per FH Film G763 9-25-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mohammad Aligholizad Anhary Sept. 23, 1998 8:20 p.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner 9239 Hourglass Place Columbia Howard 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Deys Hours Yrs. 25, 1925 73 Director 219-19-7505 Tran Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2000

Columbia

Baker

10f. Zip Code

21045

1 ☐ Yes 2 ☒ No

Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.)

Specify:

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

Specify: Asian

16b. Kind of Business/Industry

Bakery

Cocestan Anhary GOLESTAN ANHARY

18. Mother's Name (First, Middle, Maiden Sumame)

Iranian

MD

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at ange.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

pue The law requires that the death s certificate has t director, page 2 s

Box 68Z60 Division of Vital Records, P.O. Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director. p an 24 hour. To the Hospi within 24 hou To the Funer completely fil

10e. Street and Number 9239 Hourglass Place Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 荃內 No If Yes, Give Year or Detes: 1 Never Merried 2K Married þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 17. Fether's Name (First, Middle, Last) Ali Aligholizad Anhary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Saiid A. Anhary/Son 20e. Method of Disposition 1 Buriat 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications transhock, or heart failure. List only one ceuse and Immediate Cause (Final disease or condition resulting in death) Examiner Sequentielly tlst conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lsst odical **Physiclan** by Completed 25. Was cese reterred to medical exeminer? Be 2 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 5 Pending Investigation Neturel 2 Accident

Howard

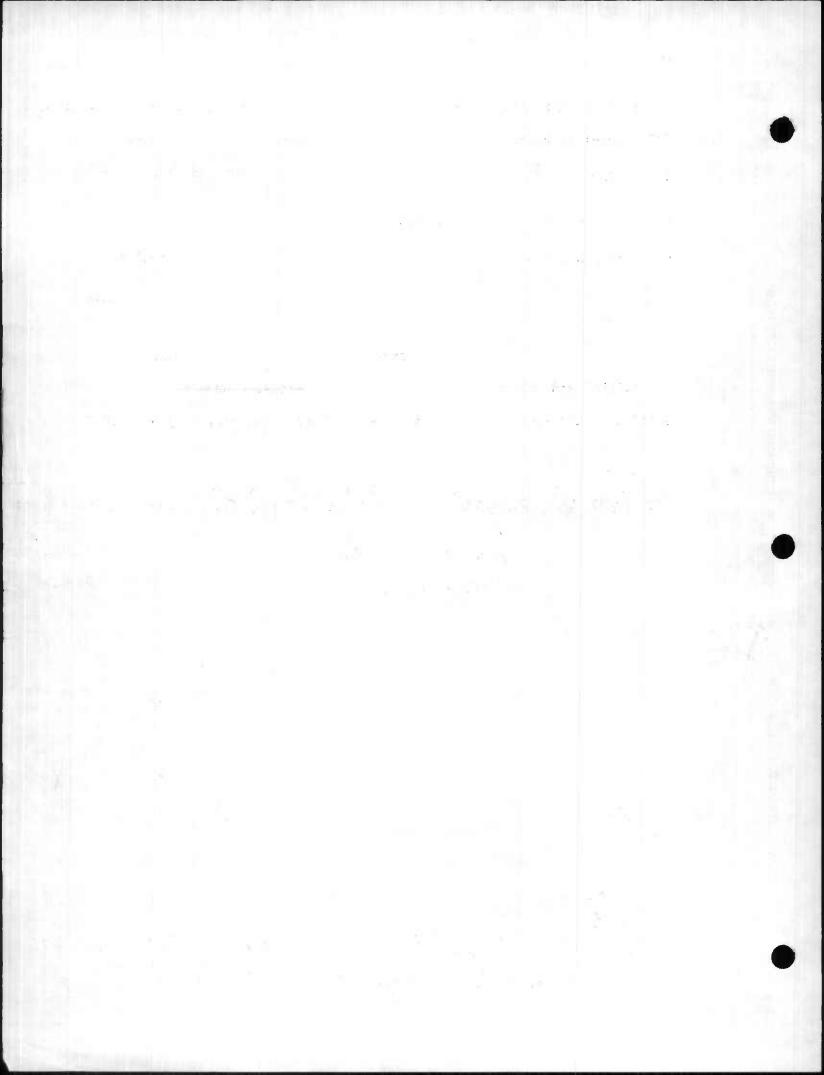
6546 Quiet Hours, Columbia, Maryland 21045 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State MD National Memorial Park 9/25 Laurel, Maryland 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707
Do not enter the mode of dying, such as cardiac or respiretory arrest, Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobscco use contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 22 No 3 Probably 4 Unknown 1 Yes 24b. Were sutopsy findings aveilable prior to completion of ceuse ot death? 24a. Was en autopsy 1 TYes 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 1 Yes 2 No 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Cartifying Physicisn: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. odical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

deeth (Item 23e) (Type, Print)

32. Registrar's Signature

31. Date filed (Mo

Medical



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	Physician /Medical Examiner]
Т	Funeral	

be executed B6x-68760. Division of Vital Records, P.O. à signed d be det certificate has t director, pege 2 s Hospital or Attending Physician: director, this funeral After s effer dea.

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Immediate Ceuse (Finel disease or condition resulting in deeth) Examin Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24a. Was en eutopsy 1 Yes 2 □ No Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☑ DOA 28e. Dete of Injury Month. Dey Year) 28d. Describe bow injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Surfect diver 5 Pending 1 Naturel 9/23 (98 1 Yes Investigation 2VZ Accident 6/03 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide pod way 1 Certifying Physician: To the best of my knowledge, death/occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29e. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of O.C.M.E SEPTEMBER 30. Name and address of person who completed cause of denur item 23e) (Type, Print) M. King 32. Registrer's Signature State Registrar

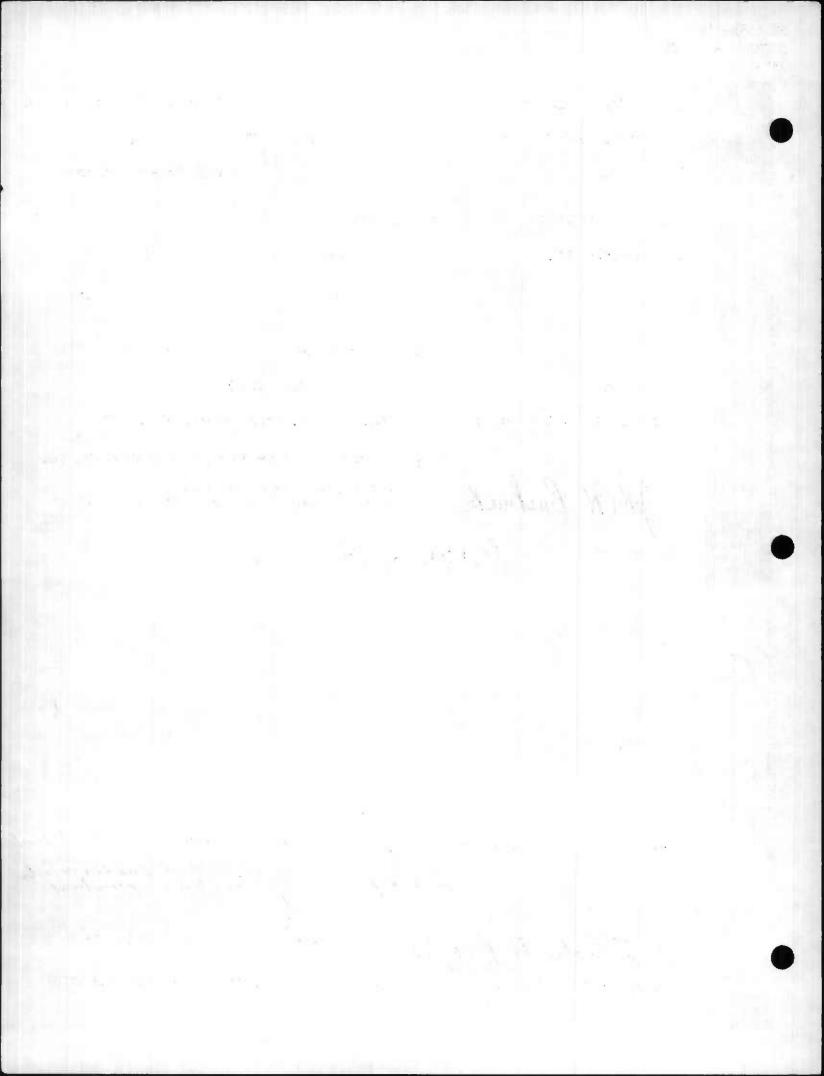
1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth SEPTEMBER 23 Yel 1998 Robert Edward Ashley 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE MARYLAND SHOCK TRAUMA If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5 Social Security Number If Under 1 Year 6 Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months Days 187 M 2□ F 72 Yrs. 219 10 9925 January 14,1926 Maryland Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene. 10a Stete 10b County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or itema 23s or 28s-f show the Medical Example: must be notified at 1 Yes 2 No White Marsh Maryland Baltimore Directo 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of Whet Country? 5807 Gambrill Rd. 21162 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 X Yas 2 □ No If Yes, Give Yaar or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - Amarican Indian, 11. Marital Stetus Black, White, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Production Worker Can Mfg. 9 other 18. Mothar's Nama (First, Middla, Maldan Sumeme) 17. Fether's Neme (First, Middle, Last) marked Anna V. Flint Unknown 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Elizabeth G. Ashley (Wife) 5807 Gambrill Rd. White Marsh, Md. 21162 Health em 27 item 2 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete = 5 permit. Pege Department of Important: If any injury or once. Holly Hill Mem. Gardens 9/26/1998 Baltimore, Co. Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility of Funeral Service Lic Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 Durkouska | 1407 OLG Eastern Avenue Esse The disaese, or complications that causad tha daath. Do not enter the moda of dying, such as cardiac or raspiretory errest, rheen failure. List only one ceuse on eech line. Approximate Interval Between Onsef and Death **Physician** /Medical Examine

> 24b. Were autopsy findings available prior fo completion of cause of deeth? 1 Yes 2□ No

> > 23,1998

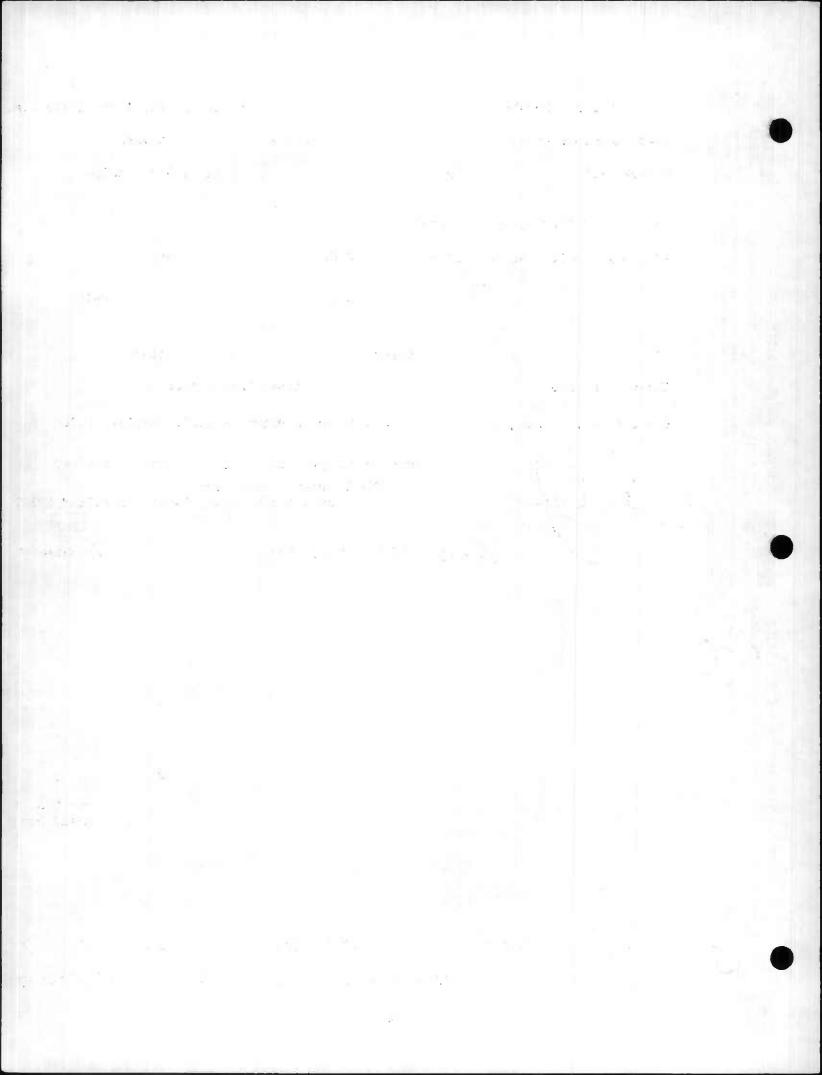
struck puch on (Street and Number of Rural Route Number, Town, State) Route 40 & Magnal

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene 98 29447

						Cei	rtificat	e of	Death		, i	Reg. No.	Comp	2771					
		1. Decedant's I	Nama (First, Middle, Li	est)							2. Date of Dea		Vasa	3. Time of De	eath				
	Physician	Anne	Marie :	Berube							Septemb	er 20.	Year 1998	10:20	a.m				
4	/Medical Examiner	4a Facility Nan	ne (If not institution, gi	ve street and nu	mber)			-	4b. City, To	wn, or L	ocation of Death	4c. Count							
	LAGITIATO	10430	Rosemont	Drive					Laur	e1		Howa	ard						
Н	Euporol	5. Social Secur		Sex	7. Age (In yrs	last birthday)	If Under		If Under	24 Hrs.	8. Date of Birt (Month, Day			lace (State or F	oreign				
П	Funeral Director			1□ M 2√1 F	79	Yrs.	Months	Days	Hours	Min.	April 4	.1919	Main	iny) ne					
-		Usual Rasidene	ce of Decedent																
	wor.	10a. State	10b. County		10c. C	lty, Town or Lo	cation						1	0d. Inside City I	Limits				
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	rec	10e. Street and		00018		daron	10f. Zip	Code				10g. Citizen of	What Coun	What Country?					
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	ins 2	11. Marital Stat		12. Was Dec	edant Evar in I	J.S. 13. 1	Was Dece	dent of F	lispanic Ori	Igin? (Sp	ecity Yes or No-	an Indian,							
	Fur Fer	1 □ Nevar N	Married 2 Married	Armed Fe 1 ☐ Yas					an, Mexicar	n, Puerto	Rican, atc.)	Bia	ick, White,	etc.					
22	build be filed within 72 hours after death with the Maryland Mantal Hygiene. Whental Hygiene. Whental Hygiene. Sale of Sale show after whental Examiner must be notified at the Madical Examiner must be notified at the Population Hygieneral Discrete.	Widow	ed 4 Divorced	If Yes, Gi Year or D	ve		1 □ Yes	No	Specify:			Speci	b: Wi	etc. hite dustry c Code) 20708 cown, State					
ŏ			15. Decedent's E	ducation		16a. Deced	dent's Usua	al Occup	ation			16b. Kind of E	Business/Inc	Justry					
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21215-0020		12	Secondary (0-12)	Ø College (rk					Reta	il								
0		17. Father's Na	me (First, Middle, Las)	18. Mother's Nam					e (First, Middle,	Maiden Suma	ma)							
au		Theode	ore Ayotte						Agr	nes l	Parent A	votte							
2	d 2 should but and Ments 7 is marked traumatic e		's Name/Relationship	(Type Print)		19b. Mailir	na Address	(Street					. State. Zip	Code)					
Maryland	d 2 la 7 la trau		le Caffrey		or	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 10430 Rosemont Drive, Laurel, Maryl													
ė,	- 9 E E	20a. Method of		Daught	20b.	Place of Dispo	sition (Nar	ne of		1110	Date	20c. Location							
õ	200	1 Burial	2 Cremation 3	Removal from		cemetery, crer	natory or o	ther pla	ce)				.,	,					
altimore,	permit. Pege Department of Important: If any injury or page.		on *5 □Other (Speci		Ва	ltimore					9/21	21 Laurel, Maryland							
Ba	Department Personal Important Import	21. Signatures	21 Section of Funeral Service Licenses 22 Name and Address of Facility Fleck Funeral Home, Inc.																
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-	14	23a. Phon. En	ter the disease, probri	plications that	ceused tha dea	th. Do not ent	er the mod	le of dyir	ng, such as	cerdiac	or respiratory ar	rest,		Approximate					
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68	A KEN B	resulting in dea	ath) Last		Due to (to (or as a consequence of):													
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Bo	at the death is to the any stached for u		1. 141												4				
o	y the sched	Part II. Other si	ignificant conditions	contributing to d	eath but not re	sulting in the u	ndariying c	ause gr	en in Part	l.	23b. Did tobacco use contributa to the causa of de								
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ita	Physician: The this certificata rel director, pag.: To Be Co	25. Was casa r examiner?	referred to medicel							e of Dea	th (Check only o	ne)		Warra late	1-				
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Division	Attending or deeth. actor: After by the fune lification	2 Accide	increase and a made				М		Yes 2	No									
<u>N</u>	after deet Olrector: J in by the	3 ☐ Suicida 4 ☐ Homici	datarminar	208. Place	of Injury - At I	nome, farm, str	eet, factor	, office			28f. Location (S City or Tox		ber or Rura	I Route Numbe	V.				
	tal or Attending P rs after deeth. al Director: After t led in by the funera Certification:	4011011110		Dund	ing, arc. (Space	197					Only of 1 of	, otato,							
		29a. Certifier	1 Certifying Pi	hysician: To the	best of my kn	owledge, death	occurred	at tha ti	me, date ar	nd place,	and due to the	ceuse(s) and n	nanner es s	lated.					
	n 24 hound n 24 hound no Funding file pletaly file edical	(Check only one)	2 Medical Exa	minar: On the b	asis of examin nar stated.	etion end/or in	vestigation	, in my c	pinion, dea	ath occur	red at the time,	date and place	, and due to	tha cause(s)					
	within within to the comple	≥ 29b. Signature and title of certifiar 2 29c. Licansa number									29d. Date sign								
	/	1	A leul	www			1	136	17/	6		Serte	whe	21,19	46				
	15	20 Name and	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) ANDREW KUNNATE (317 Cherry LANE Laurel, Mc 2076 31. Date filed (Month Day Year) 32. Register's Signature																
	1	41	15W Ku	completed cau				10	6	NS	1.0	4001	" U.	1570	202				
	0	1	Month, Day, Year)		Registřar's Sign	eture	rero	4			, , ,		1	C. 201					
	State Registrar		SEP 25	1998	Bener		1. 1	par	Ks										



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔈 Amend: #18 Per FH Film G763 9-25-98RC Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth BOYER **Physician** PAULINE 2/ 98 4c. County of Deeth /Medical 4e. Fecility Neme (If not institution, give street end number 4b. City, Town, or Location of Deeth **Examiner** Baltimore
r If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Yeer) Bon Secour Hosp If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1□M 2XF Yrs. Director 236-32-1077 06 01 17 V.A. Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at Director 1X Yes 2 No MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò or itama 23a Funeral 3404 Dolfield Ave Apt 207

1. Maritel Status

12. Wes Decedent Ever in U.S. Armed Forces? U • S • A • 14. Race - American Indien, Bleck, White, etc. 21215 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married TY Yes 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No by Specify: 3℃Widowed 4 □ Divorced "natural", Black Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 1 end 2 should be filed within Health end Mental Hygiene. em 27 is merked other than " Elementery/Secondary (0-12) College (1-4or 5+) Social Security Adm 12th grade 2yrs Clerk 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be AMERICA MARTIN Edward S. Smalls American Martin 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 s
Department of Health en
Important: If item 27 is
any Injury or other trau Helen Johnson-daughter
20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)

NW, Washington DC 20c. Location - City or Town, State 20011 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore National 9/29/98 Baltimore, MD 21. Signature of Fuperal Service Licensee 22. Name end Address of Fecility March F/H West 43. Enter the disease, or complications that coused the death. Do not enter shock, or hearty allure. List only one couse on each line. 4300 Wabash Ave, Baltimore, Md enter the mode of dying, such as cardiac or respiretory errest, 21215 Approximete Intervel Between Onsel and Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting In death) Examiner Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieled events resulting in death) Lest Physician/Medicai Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 2□ No 3 Probably 4 Unknown Records, PV 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? neoplasm Obstructive pulmonary disease Chronic certificate 1 ☐ Yes 2 ☐ No Division of Vital I or Attanding Physician: after death. 25. Wes case referred to medical examiner? director, Be 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1□Yes 2DNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To funeral 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 1 Seleturel 2 Accident 5 Pending Investigation 2 🗆 No 1 Yes Director: / 6 Could not be 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Directompletely filled in b 4 Homicide 1 Certifying Physician: To the bast of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29a, Certifier

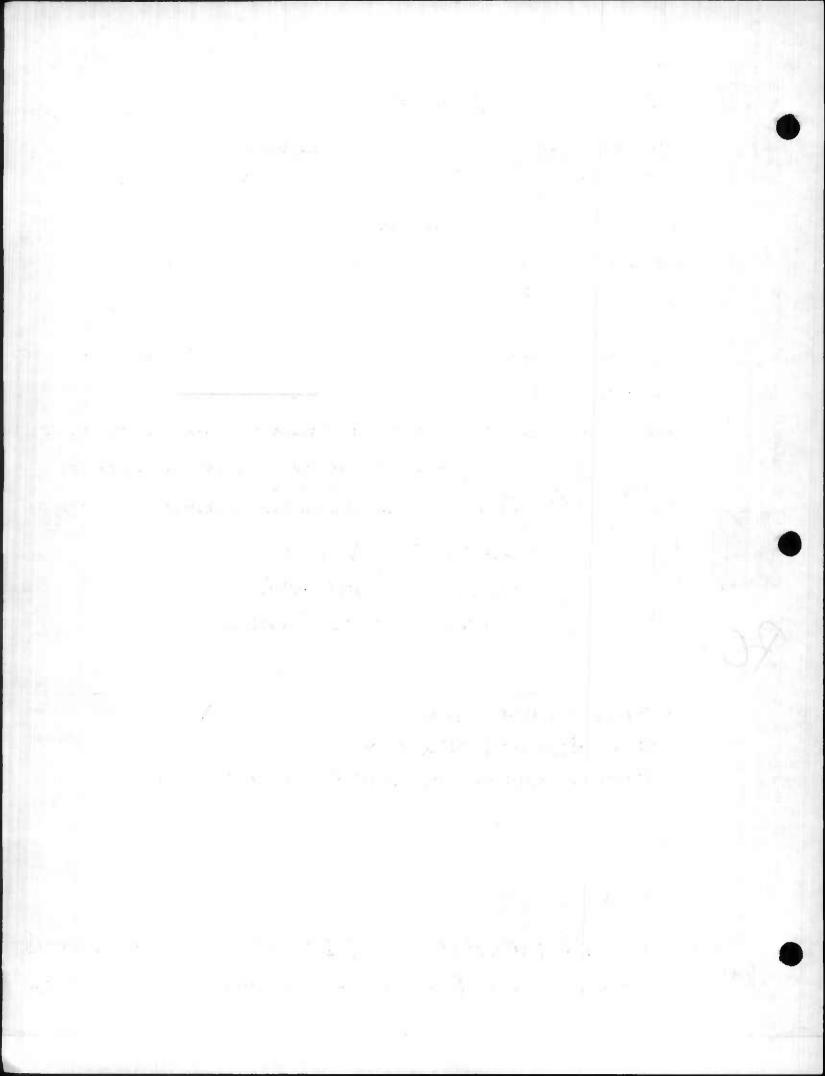
State Registrar 29b. Signeture end title of certifier

30. Neme end eddress of person (Item 23e) (Type, Print) CHRISTOPHEK 31. Dete filed (Month, Day, CEP 2

700 WASH, BIUD, BALT MD 21230

29d. Date signed (Month, Dey, Year)

32. Registrer's Signeture Rower



Physician /Medical

Examiner pue

Examiner 68760 edical ğ o signed to þ Division of Vital Records, Completed certificate has b Attending Physician: director, Be 2 this funeral After efter deeth. Director: Af

6

Hospital 24 hours

To the Hosp within 24 ho To the Fune completely fi

filled in

edical

4300 WABASH AVE. BALTO., MD 21215 for the different, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, heart fall the List only one ceuse on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final ALCOHOL, COCAINE AND NARCOTIC INTOXICATION disease or condition resulting in death) Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated evenIs resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 4 Unknown 1 Yee 2 No 3 Probably 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy Yes 1 Yes 2 No 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 XYes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of AM 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred FOUND 9-23-98 FOUND: 900M 1 Naturel 5 Pending 1 Yes 2 No UNKNOWN investigation 2 Accident 6 🕻 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3822 BONNER ROAD. 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide FOUND: RESIDENCE BALTIMORE CITY MD. 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

3. Time of Deeth

0935AM

9. Birthplece (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

MD

SEPTEMBER 24, 1998

Yeer

NA

State Registrar

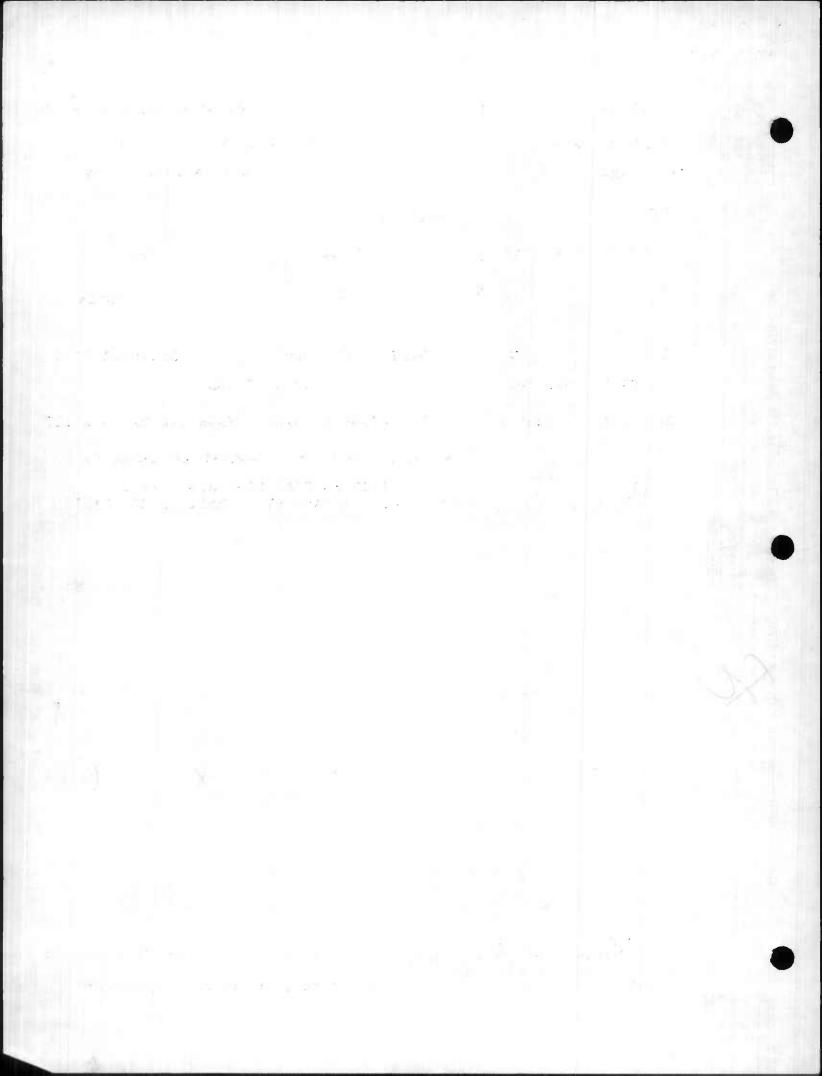
ed cause of death (Item 23a) (Type, Print) PHENNUNE MIKENS 31. Dete filed (Month, Day, Year) SEP 2 5 1998

30. Neme end eddress of person who complete

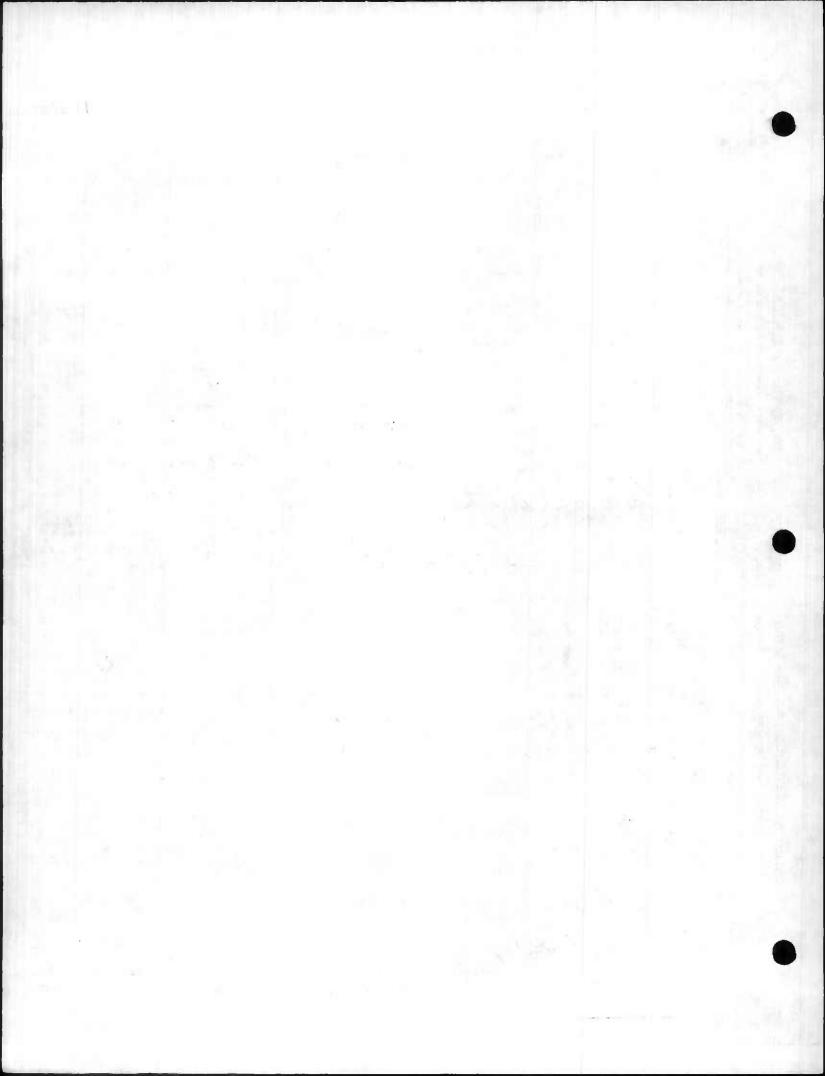
32. Registrer's Signature

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.



DHMH 16 Rev 6/95

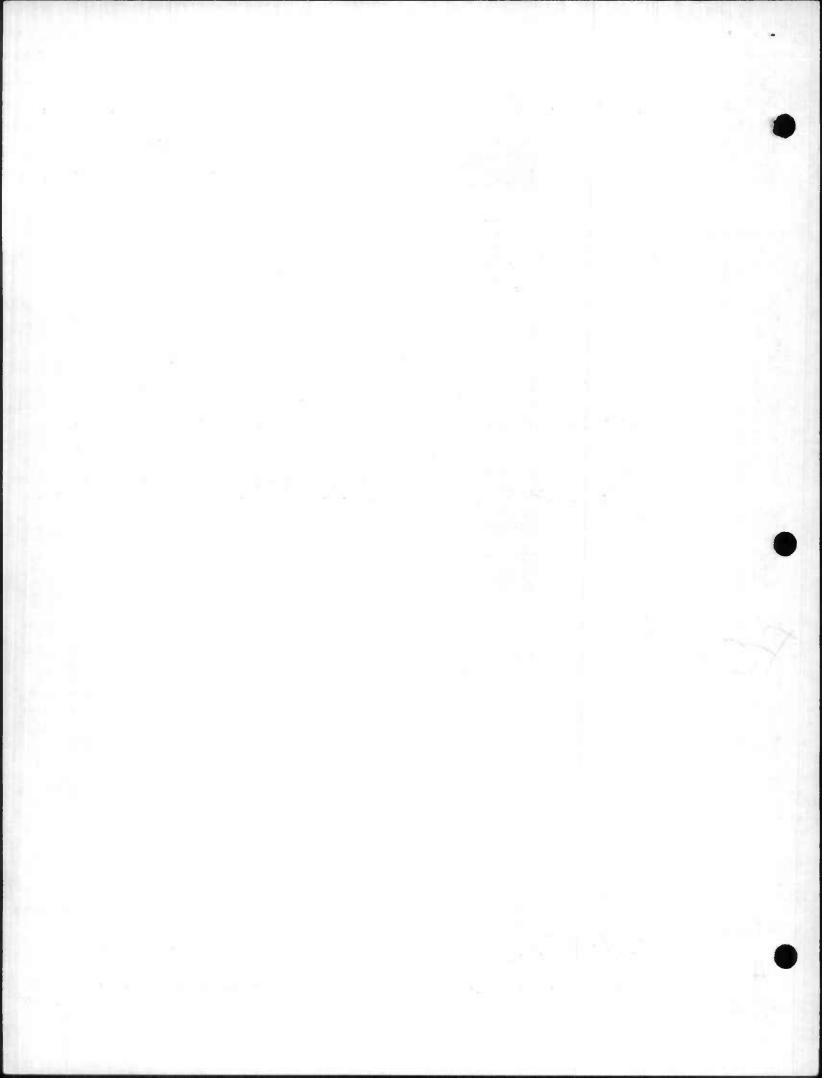


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State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Neme (First, Middle, I	ast)			tificate of		2. Dete of De			3. Time of Death		
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kaminer		4e. Fecility Neme (If not institution, g	ive street end number	r)			4b. City, Town, or		4c. County				
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neral			Sex 7. A	ige (In yrs. k		If Under 1 Yeer Months Deys				9. Birthplac	e (State or Foreign		
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**	-	10e. Stete 10b. County		10c. City	Town or Loc	ation				10d	inside City Limits		
for tor		MD N/A		В	altimo	ore					1□Yes 2□No		
irec	3	10e. Street and Number				10f. Zip Code		10g. Citizen of Whet Country?			?		
a io		241 N. Spring	Court			2123	3.1		USA				
Most must be notified Funeral Director		11. Meritel Status	12. Wes Decedent Armed Forces	t Ever in U,S	3. 13. W	13. Wes Decedent of Hispenic Origin? (S If Yes, specify Cuban, Mexican, Puerto				e - American			
P S	5	1 Never Merried 2 Merried 3 Widowed 4 Divorced		No		Yes 27 No		no moan, etc.)	Specify	k, White, etc			
8		15. Decedent's (Specify only highest of	Education	16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Bu	usiness/Indus	itry		
3 Widowed 4 Divorced 15. Decedent's (Specify only highest of the control of the			College (1-4or	5+)	life. Do	O NOT use retire	during most or wo	orking					
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5 3		Margaret Jone		nd			t and Number or F				The state of the s		
	1	20e. Method of Disposition	s / File		241 1 ece of Disposi	N . SPL Ition (Neme of etory or other ple	ing Cou	rt bal	20c. Location -				
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eny injury		21. Signature of Funeral Service Lio	regorch	ik	22(Nemadd 299 Fre	onFostoc derick	iety of Rd. Ba	Maryl ltimor	and,	Inc. 21228		
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ian	1	23a. Part1. Entar tha disease, of earthplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line.											
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		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaese or injury that initiated events	c. SMO	KINC							YEAR		
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sicia	F	Part II. Other significant conditions	contributing to death I	but not resul	ting in the und	derlying cause gi	ven in Pert i.	23b. Did tobacco use contribute to the ca			e cause of death?		
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tion		1 Naturai 5 Pending 2 Accident Investigati	(Month, De	ey Year)	injury	28c. inju Wo M 1	rk? Yas 2 □ No	200. 0000100	now injury occurr	90			
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DHMH 16 Rev 6/95



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

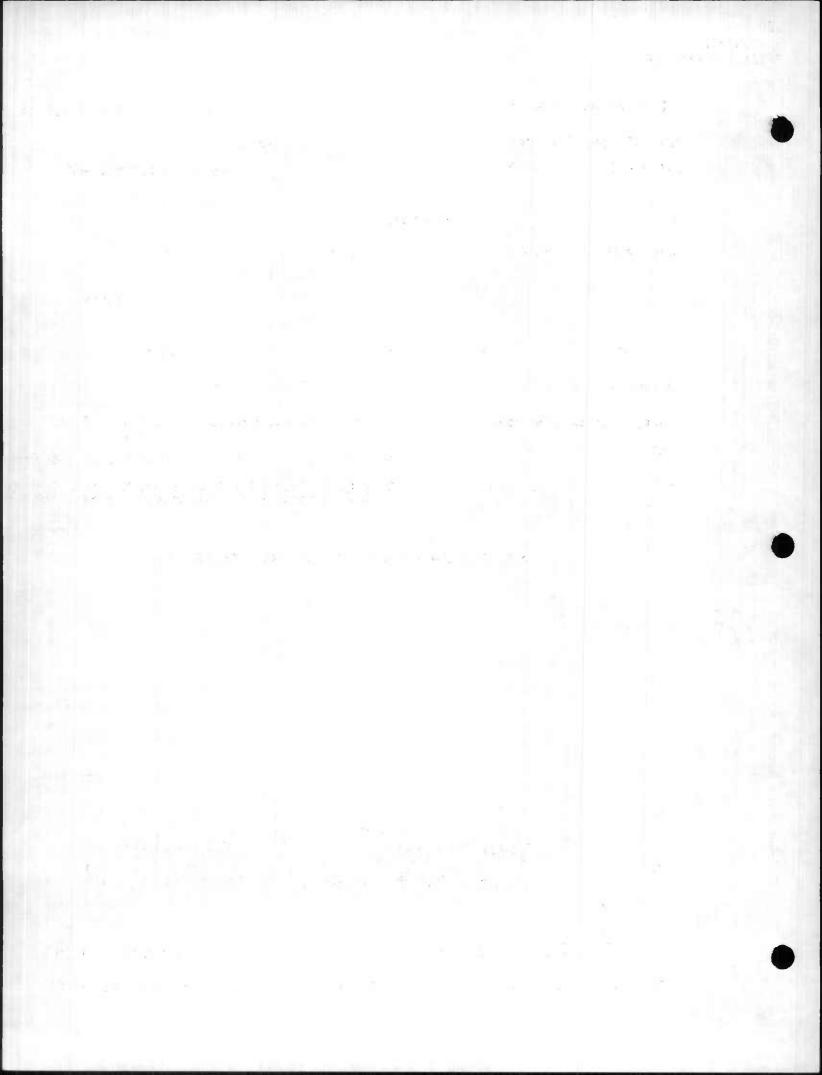
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runerai	11. Merital Status		12. Was Decedent Armed Forces?		S. 13. V	/as Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or N	lo- 14. Race	- Americer	
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	shock, or he	art failure. List only	nplications that caused one cause on each li	ne.	. Do not ente	i the mode of d	ring, such es cardiac	or respiratory	arrest,	Ir	nterval Between
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State Registrar JOSEPH PESTANER, M.I 31. Date filed (Month, Day, Year) SEP 2 5 1998

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



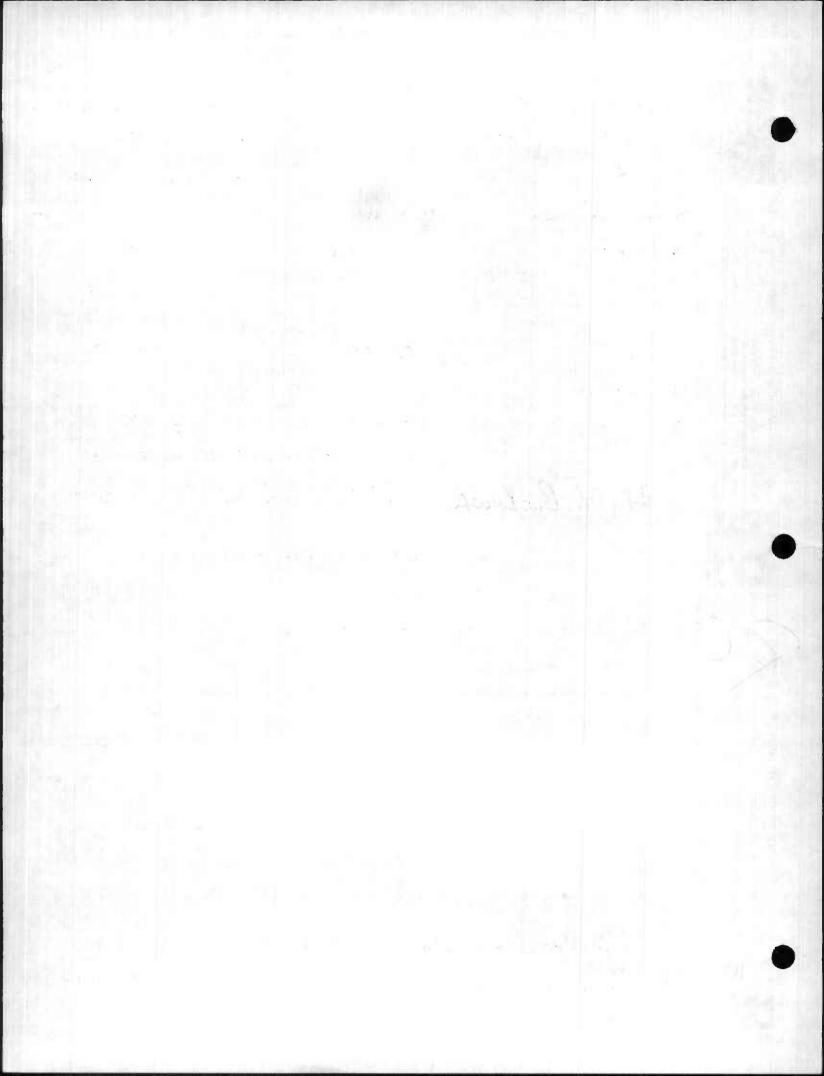
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State of Maryland / Department of Health and Mental Hygiene

	Decedant's Nama (First, Middla,	Last)		Cer	tificate	ot De	eath	2. Dete of Dea	Reg. No.	3. Time of Deeth		
Physiçian /Medical	Margaret Lore				30	45.0	Shi Taum or f	Month Septemble Location of Death		1998 8:00 am		
Examiner	4s Facility Nema (If not institution, IVY Hall Geriatr					M	iddle 1	River	Balti	more		
Funeral Director	218 26 2776	Sex 1□M 2∏xF	7. Age (In yrs. 66	last birthday) Yrs.	if Under 1 Y Months D		Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De) July 15		9. Birthpiace (State or Foreig Country) Maryland		
death with the Maryland ms 23e or 28e-f show trivial be martled at	10e. Stete 10b. County Maryland Baltime	ore		y, Town or Loo iddle I					10d. i			
Uffer death with the Mark terms 23s or 28s-fs	10e. Street end Number 61 Torque Way				10f. Zip Code 21 220				10g. Citizen of Whet Country? USA			
o20 urs after alt, or its	3 □XWidowed 4 □ Divorced	Armed Fo	2⊠No ve	I.S. I3. Was Decedent of Hispenic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:			pecify Yas or No- o Rican, etc.)	s or No- etc.) 14. Race - American india Black, White, etc. Specify: White				
2121 I within piene. r then	15. Decedent's (Specify only highest) Elementary/Secondary (0-12)	Education grade completed) College (ent's Usuei O kind of work d OO NOT use re rator	Susuel Occupation of work done during most of working (OT use retired) Telephone						
lore, Maryland 2 ges 1 and 2 should be filed t of Health and Mental Hygis if flem 27 is marked other or other traumatic event. To Be Co	17. Father's Name (First, Middle, La	st)				18. Mothar's Neme (First, Middle, Maiden Surnama)						
Maryland d 2 should be file th and Mental Hy 7 is marked othe trsumatic event	Gary C. Pollock						Sarah F	Rice				
2 a s s	19e. informent's Neme/Reletionship			19b. Meiling Address (Street end Number or Rurel Routs Numbe								
1 and 1 health Health om 27 other tr	Malinda Scales (1	Daughter					or. Bal	Baltimore, Md. 21239 Date 20c. Location - City or Town, S				
Baltimore, n permit. Pages 1 and Department of Health Important: If then 27 any injury or other to	20a. Mathod of Disposition 1											
Baltim permit. Pa Departmen Important: any Injury	21. Signature of Funeral Service Lie	R. la	ush	B	Name end A ruzdzii 407 Old	nski	Funera	al Home l	P.A. ssex, M	d. 21221		
Physician /Medical Examiner	Immediate Cause (Finel disasse or condition rasulting in death)		erebo		inter				rest,	Approximate interval Between Onset and Death		
p ii d		- b	Hypc Due to (o		100							
nimass to mount no physicilin and five bolestiem.	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last	с	Due to (or			.ae	mig					
olary		d										
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ecords aw requires as been sign 2 should be pleted by								24e. Was perfo	en eutopsy med?	24b. Were eutopsy findings eveilable prior to completion of cause of death?		
I Rec								101	Yes 2 No	1 ☐ Yes 2 1 No		
VITAL The stellars The contilicate rescion, pag	25. Wes case referred to medical examiner?					T -	5. Place of Dea	ath (Check only o	nne)			
ang Physic Alter mis or tuneral dire	1 ☐ Yes 2X No 27. Manner of Death 1 [XNature] 5 ☐ Pending		of injury (th, Dey Year)	ER/Outpetien 28b. Time of Injury		Injury et Work?		lome 5 Resid				
Division of the or Attending P is after death. St Director: After 1 led in by the funeric Certification:	2 Accident Investigal 3 Suicide 6 Could no 4 Homloide determine	t be 28e. Plece	of injury - At he		M eet, fectory, of		2 🗆 No	28f. Location (Street end Num vn, Stete)	ber or Rural Route Number,		
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Within 2 To the comple	one) 29b. Signature and title of certifier	end men	ner stated.		29c. Li	icensa nu	umber		29d. Data signi	ad (Month, Dey, Year)		
F ≇ # 8	> Done	ter		WD.	I) 31	464		9/2	-3198		
10	30. Name and address of person who SHOAII3 A - HASH	mo completed caus	se of deeth (item -109 Ba	123e) (Type, I	Print) Ver No	ech	1201	Baltim	ne r	MD 21221		

32. Ragistrar's Signeture

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Kathleen Cullen Sept. 23,1998 6:30 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Home, 2909 Whitney Avenue Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2ØF Hours 89 Yrs. Director 129-24-9234 Dec. 9, 1908 New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits YYes 2□ No Director 28a-f Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 2909 Whitney Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white þ I Hygiena. other than "natural", c vent, the Medical Exar 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Patrick Michael Cunningham Ruth Guiry 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If Item 27 to or other tra Thomas W. Cullen 2803 Whitney Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ②CXCremation 3 ☐ Removal from State Department Hilltop Service Co. 9/26/98 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signeture of Fifneral Service Lice 22. Name and Address of Facility Burgee-Henss Funeral Home, P.A. lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, one cause on each line. 3631 Falls Road Baltimore, MD 21211 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner sician and buriaf-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical Due to (or as a consequence of): for use signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use Contribute to the cause of death? Division of Vital Records, P.O. 1 Yes I No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 24 1 ☐ Yes 2 ☐ No cartificata or Attending Physicien: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred After this 27. Manufer of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural n 24 hours stier death.

ne Funerel Director Aft
he Funerel Director Aft 1 Yes 2 No 2 | Mccident (3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29d. Date signed Month, Day, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item A3a) (Type, Print)

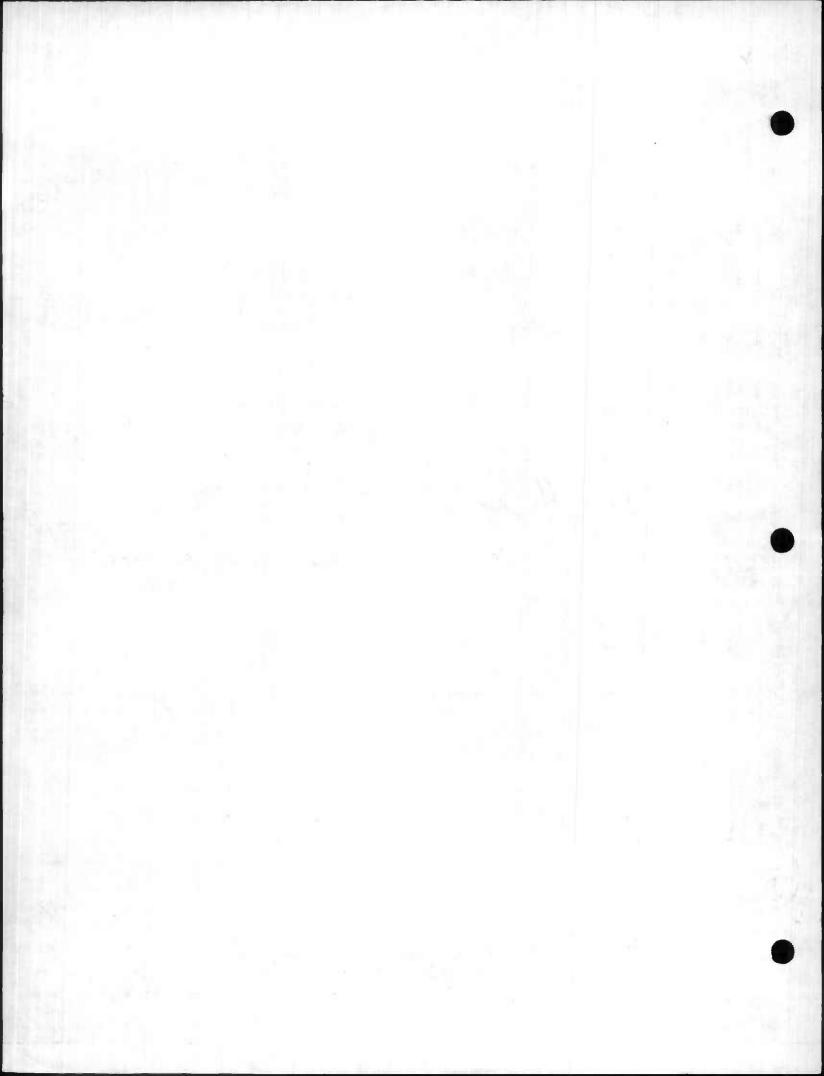
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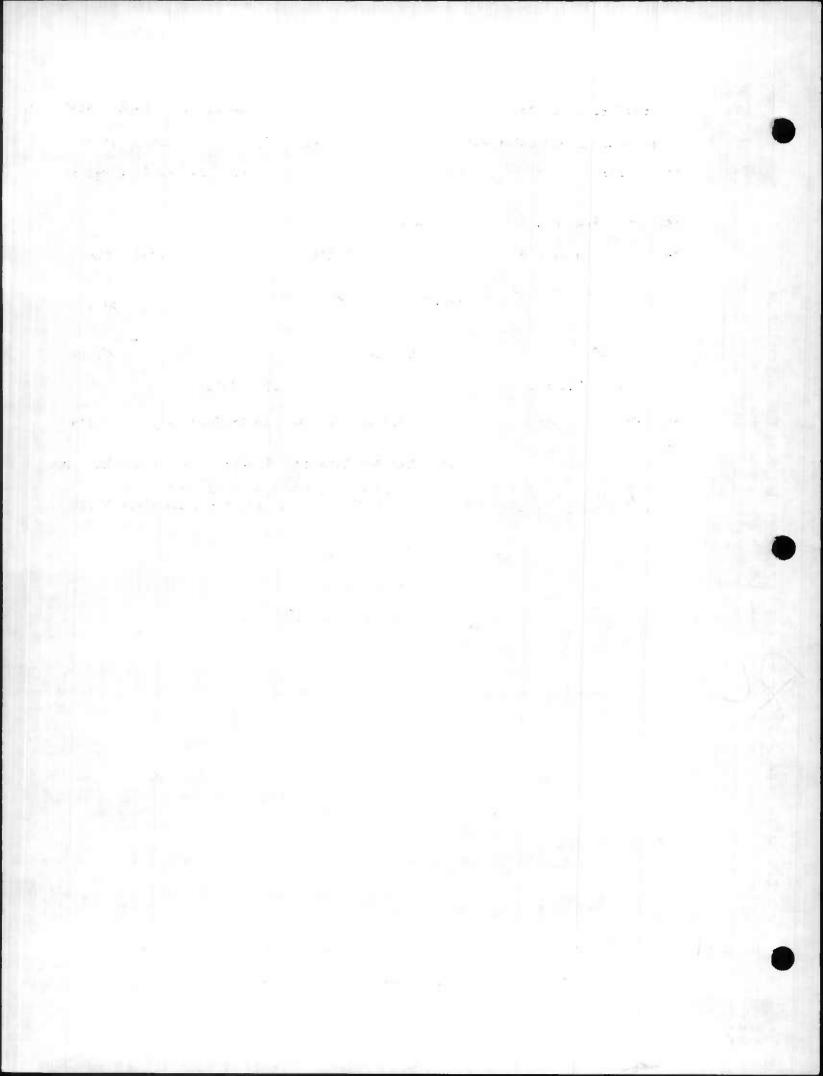


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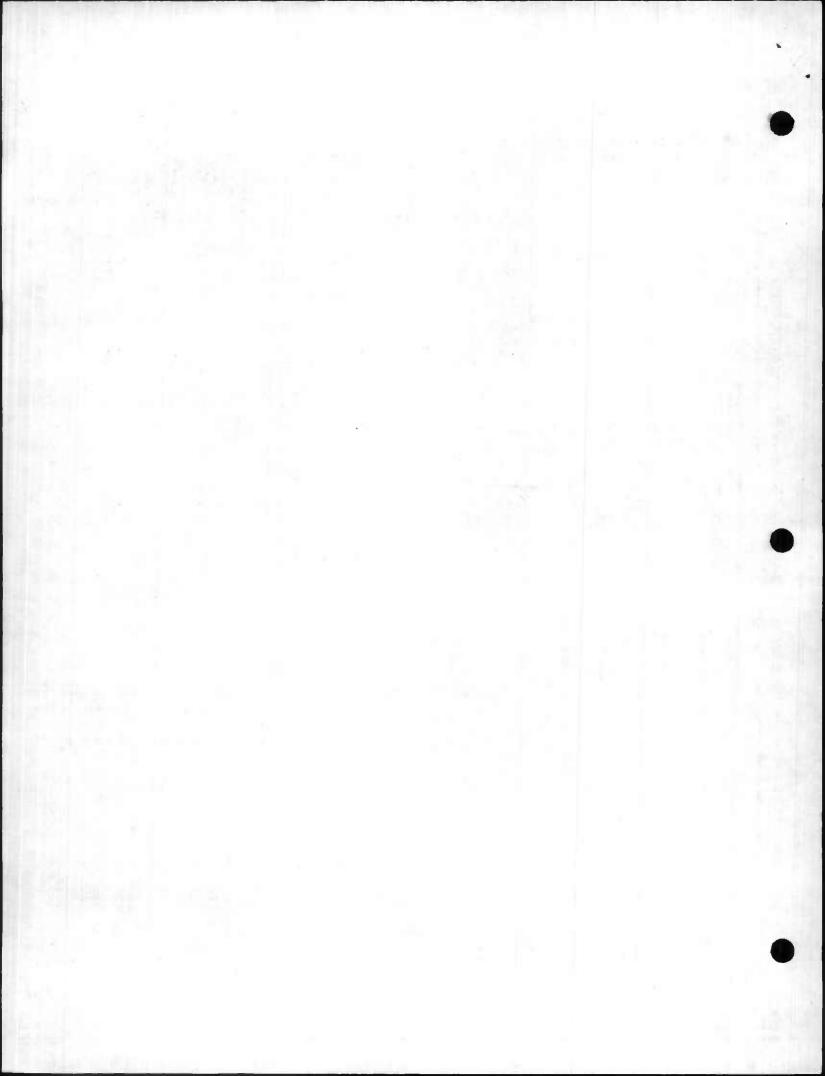
State Registrar 31. Date filed (Month, Day, Yeer) SEP 2 5 1998 32. Registrar's Signature

Sporks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No. ~	18 29456							
	1. Decedent's Nama (First, Middle, Last)	2. Data of Death	Day Year // -							
Physician /Medical	Clanda Cospins	Month Day	19, 1998 11:51 Am							
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	ocation of Death 4c. Cou	nty of Death							
	Northwest Hospital Center Randallsto	wn Balt	imore County							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Data of Birth (Month, Day, Year)	Birthplaca (Stata or Foreign Country)							
Director	213-01-5075 15 M 2 F 90 Yrs. Months Days Hours Min.	APR. 4, 1908								
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oto	Maryland Baltimore County Pikesville		1 □ Yas 2 No							
or 28e-f e	10e. Street and Number 10f. Zip Code	10g. Citizen	of What Country?							
23a	216 Oak Avenue 21208		U.S.A.							
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Semil. Peg Separtment mportant: h any injury o		9-23-98 Woodla	awn, Maryland							
pearline pea	21. Signeture of Funaral Service Licentum 22. Nama and Address of Facility Loring Byers Fune	ral Directors	Inc							
40500	Tother (400804) 8728 Liberty Rd.									
	23 Part / Enter the disease, or completition that caused the death. Do not enter the mode of dying, such as cardiac should or heart failure. List only one cause on each line.	or raspiratory arrast,	Approximata Intarval Between							
Physician			Onset and Deeth							
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	11/10 /18/ 1/45)/4	SULT	- 17, 1178							
19	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)	1								
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State	31. Date filed (Month, Day, Year) 32. Registrar's Signatura									
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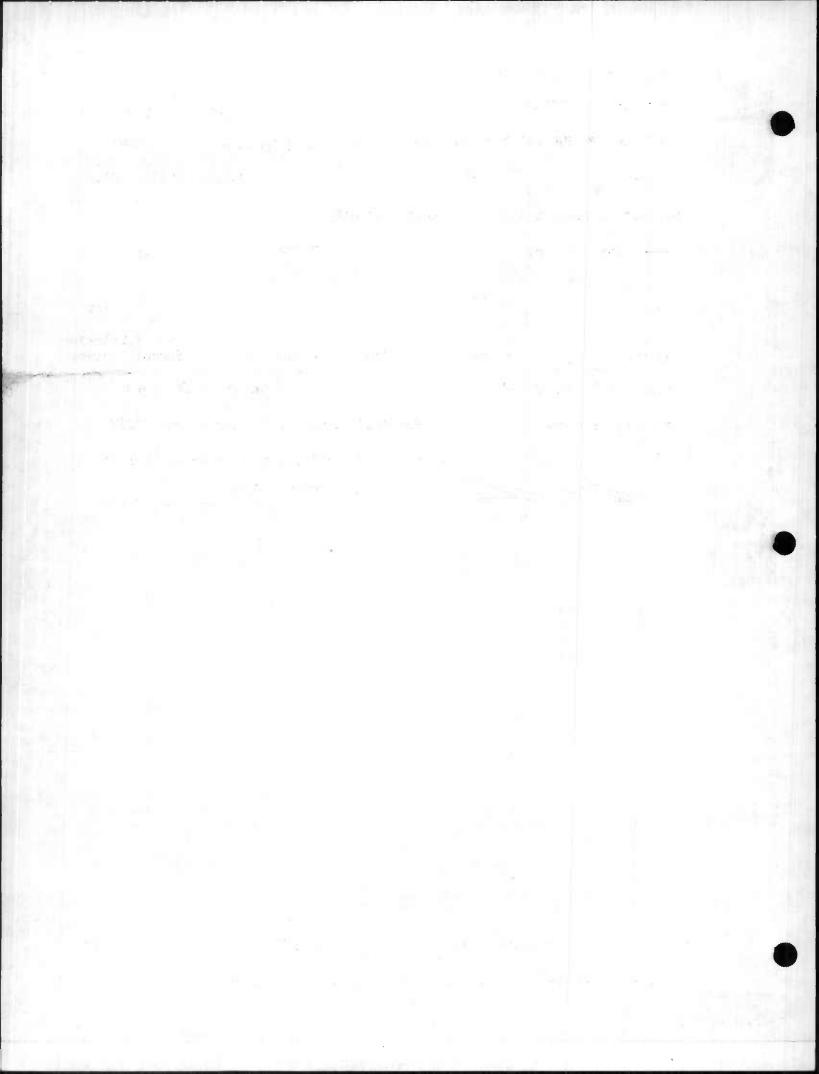
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State of Maryland / Department of Health and Mental Hygiene

		Oe, 19b per FH G764 10/3 1. Decedent's Name (First, Middle, Last				rtifica			2. Date of De	Reg. No.		3. Time of Death
Physicia /Medic		DOROTHY E. CONAL	RD						SEPT	22 199	Year	10.10 AM
Examin		4a. Facility Name (If not institution, give	street end numb	er)				4b. City, Town, or I				10:18 AM
		CHESTERTOWN NURS:	ING & RE	HAB.	CTR.			CHESTER	TOWN	k	CENT	
Funeral Director		5. Social Security Number 6. Se 215-42-5239 Usual Residence of Decedent	M 2CXF	Age (In yrs	(lest birthday) Yrs.	If Und Months	er 1 Yeer B Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De Dec. 10	th y, Year)		ace (Stete or Foreign ry)
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23a or 28	Funeral Director	10e. Street and Number 01 206 Paddington Ro	d.			10f. Z	ip Code	21212		10g. Citizen of What Country? USA		
0,1	by	11. Marital Slatus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, GiveX Year or Date	es? □ No X		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes						n Indian, tc.
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D A	o Be	17. Felher's Name (First, Middle, Last) Clarence Taylor Cloud 18. Mother's Name (First, Middle, Meiden Surneme) Clarissa Belle Eastburn										
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em 27 is me ther traum		Mary Pat Blanton			206 F	add:	ingto	n Rd. Ba	ltimore	Md. 23	1212	
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njury or	4 ☐ Donetion 5 ☐ Other (Specify)			Ch. Cem.	9-26-9	3 Cheste	er Co.	,PA.				
important: If hem 27 any injury or other to once.		21. Signeture of Funeral Service Licens	1/1/20	-	- 1	assa	ahn F	ss of Facility uneral Ho ir Rd. B		e. Md. 2	21236	
ysician Nedical aminer		23a. Pert1. Enter the diseese, or compt shock, or heart failure. List only of timmediate Ceuse (Final diseese or condition resulting in death)		ea TI	ON PI	VEL	ımo		or respiratory a	rresi,	į	Approximete Interval Between Onset and Deeth 2 days
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o physician and es the burial-transit	Examin	Sequentielly list conditions, if any, leading to immediale cause. Enter Underlying).	Due to (or as a conseq			SIVE)				2 days 10 days >5 yrs.
ding physic	/Medical	Ceuse (Disease or injury thei initiated events resulting in death) Last			or as a consequ							
d for t	iciai	Pert II. Other eignificant conditions cor	tribution to death	but not res	culting in the ur	dedvina	cause an	en in Pert I	22h Did	Johnson une on	ntelbute to	the cause of death?
signed by the ettending be detached for use	y Phys	ATRIAL FIBRI			sulting in the ur	idenying	cause giv	en in Pan I.		Yes 200		ably 4 ☐ Unknown
as been signal 2 should b	Completed by Physician/N								24a. Was perfo	an autopsy med?	avai	re autopsy findings table prior to apletion of cause eath?
director, page 2	် ပ								10	res 2 No	10	Yes 20 No
rector	o Be	25. Was cese referred to medical exeminer?	ospital:				Oth	26. Plece of Dea				
50	-	27. Manner of Death Selection 1 5 Pending 2 Accident Investigation	28a. Dete of In (Month, L		28b. Time of Injury	-	28c. Injur Wor	4 Konursing H	ome 5 Resident	dence 6 □Oth now Injury occur		
To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Placa of building,	Injury - At h etc. (Specii	ome, farm, stre	et, facio	ry, office		28f. Location (: City or Tox	Street end Numb vn, Stete)	ber or Rural	Route Number,
the Funer pletely fill	edicai	29a. Certifier Check only one) Certifying Phys	Ician: To the bester: On the basis and menner	of examina	owledge, death ation and/or Inv	occurred estigatio	at the tin	ne, dete and place, plnion, death occur	and due to lhe red et the time,	cause(s) and madate and place,	anner es sta and due to t	ted. the ceuse(s)
Tom	2	29b. Signature end tille of certifier	una	no	YE	25	D Z	+1587		29d. Date signe	od (Month, D	
		30. Name and address of person who co	mpleted cause of	death (Iter	n 23a) (Type, F	Print)			-			

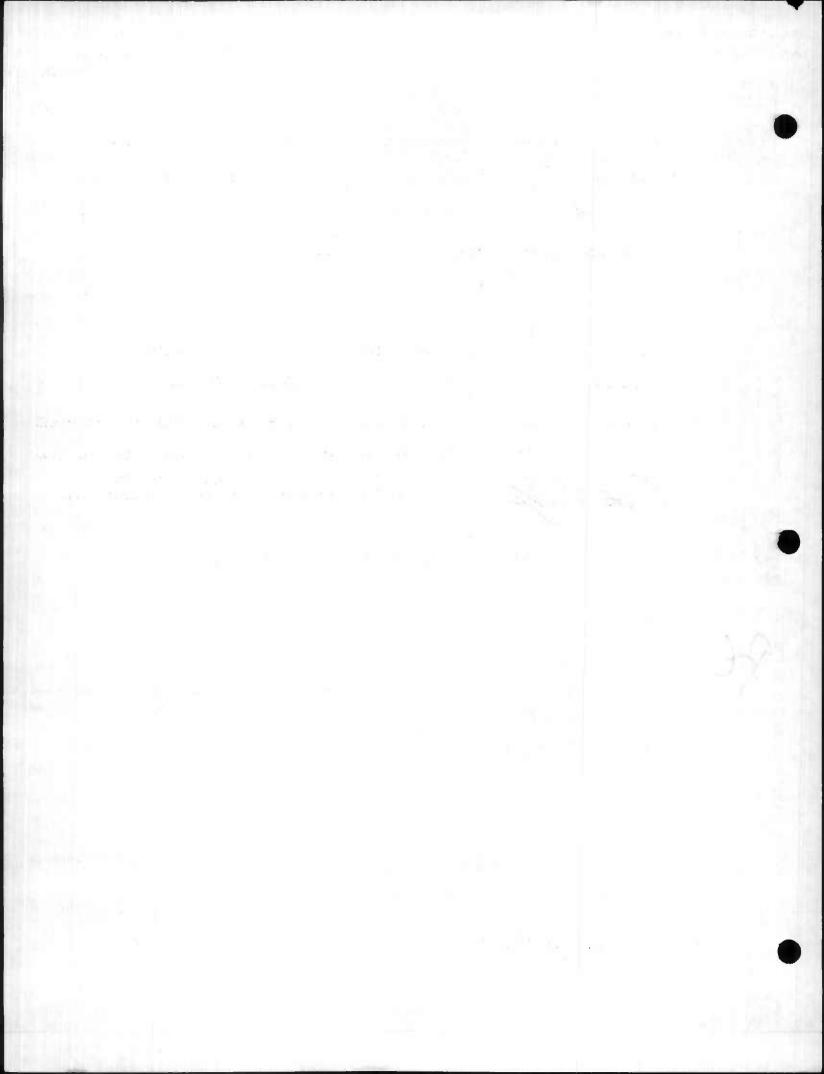
DHMH 16 Rev 6/95

Registrar



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Physical		Decedeni's Neme (First, Middle, Las	()	Ce	ertificate of	Death	2. Dete of De		3. Time of Deeth	
Physic /Med		ROY CUX					Month 5 Pm	ism 22	1998 843 12	
Exam		4e. Fecility Neme (If not institution, give				4b. City, Town, or Li			of Deeth	
1 -7				22/1728		BALTIMO			V/4	
Funera Director	_	5. Sociel Security Number 6. Si 120-09-5606 Usual Residence of Decedent	7. Age (In	yrs. last birthday Yrs.	Months Dey		8. Dete of Bir (Month, De 11/9/	th by, Year) /1917	Birthpieca (Stete or Foreig Country) Maryland	
the Maryland 28a-f show	tor	10a. Stete 10b. County N/A		altimor					10d. Inside City Llmit 1 Yes 2 N	
ath with the 23a or 28	Funeral Director	10e. Street end Number 5005 Benton He.	ights Avenu	ae .	10f. Zip Code 21:	206		10g. Citizen of Whet Country? U.S.A.		
ING Z1Z13-UUZU be filed within 72 hours after death with the Maryland tal Hygiane. I of their than "netural", or frems 23a or 28a-f show event, the Madical Examiner must be nothed at	by	11. Maritel Stelus 1 Never Merried 2 Married 3 Widowed 4 Divorcad	12. Was Deceden! Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:	in U,S. 13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No	Hispenic Origin? (Sp ben, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Reco	e - American Indien, k, White, etc. White	
ice, Maryland Z1Z13-UUZU s 1 and 2 should be filed within 72 hours af Health and Mental Hygiane. tem 27 is marked other than "netural", or other traumatic event, the Medical Evan	Completed	15. Decedent's Ed (Specify only highest grad Elementery/Secondery (0-12)	ucation de <i>completed)</i> College (1-4or 5+)	16a. Dece (Give life. Self		upalion e during most of work ed)	ling	16b. Kind of Bu	siness/Industry	
lied y her t		17 Folhada Nama (First Middle 1 and)		Serr	Employ	18. Mother's Name (First, Middle, Maiden Sumeme)				
Maryland 212 d 2 should be filed within th and Mental Hygiane. 7 is marked other than traumatic event, the M	To Be	17. Felher's Neme (First, Middle, Last) Herbert Cox				Maiden Sumem Lingsly	θ)			
Adryia 2 should I and Meni is marke numetic		19a. informent's Neme/Reletionship (7	ype, Print)	19b. Mail	ing Address (Street	et end Number or Rur	al Route Numb	er, City or Town,	Stete, Zip Code)	
e, IN 1 and 2 Health em 27 i		Helen Cox		5005		Heights	Avenue	Baltimo	re, Maryland	
Page nant o		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removel from Stete	Db. Plece of Disp comptery, cre Parkwoo	osition (Name of metory or other pi demete	ery 9	Dete 0/26/98		City or Town, State ore, Maryland	
Dalltime permit. Pag Department important: If any injury o		21. Signature of Funeral Service Licent			2. Neme end Add	ress of Fecility Jo ir Road Ba	ohn C.	Miller Mary	Inc. land 21206	
Physician		23a. Pert1. Enter the disease, or comp shock, or heert feilure. List col-	stions Ihel caused the ceuse on each line.	deeth. Do not en	iter the mode of dy	ving, such es cardiac	or respiretory e	rresl,	Approximete Intervel Between Onset end Death	
/Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)	e. M355111=	CONEY to (or es e conse		MUMK	MGE		18H	
A CO / OU, Incatable executed In providen and	Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	G		or es e consequenca of):					
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d by the date of t	Physician	Pert II. Other significant conditione co	ntribuling to death but no	resulting in the u	underlying cause g	iven in Pert I.		\/	tribute to the cause of death	
es that the igned by the datech	by Ph	BYPUNTENSIE	N				1 🗆	Yes 2DANo	3 Probably 4 Unknow	
aw requir	Completed	Amm Fish	nous					en eutopsy ormed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?	
ysician: The last certificate he director, page	mo.						10	Yes 2 No	1 ☐ Yes 2 ☐ No	
VICIAN: The certificate rector, pag	Be (25. Wes case referred to medical examiner?				26. Piece of Deat	h (Check only o	one)		
- Z w O	10	1 ☐ Yes 25 No		2 ☐ ER/Outpetie	nt 3 DOA	ther: 4 \sum Nursing Ho	me 5 Resid	dence 6 Othe	er (Specify)	
ath. r: Aftar	ation:	27. Menner of Deeth Neturel 5 Pending 2 Accident Investigation	28e. Date of Injury (Month, Dey Yea	28b. Time of Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe I	how Injury occurr	ed	
LIVISION al or Attanding a after death. Il Director: After ad in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - building, etc. (Sp.	At home, farm, st ecify)	reet, factory, office		28f. Location (3 City or Tox	Street end Numbern, Stete)	er or Rurel Route Number,	
To the Hospital or Atta within 24 hours after de To the Funeral Directo completaly filled in by the	edical (29e. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my ner: On the basis of exar end manner steted.	knowiedge, deet ninetion end/or in	h occurred et the investigetion, in my	time, dete end pleca, oplnion, deeth occurr	end due to the red et the time,	ceuse(s) end me dete end place, e	nner es steted. and due to the cause(s)	
To the within 2 To the comple	₩ W	29b. Signeture end tille of cartifier								
17		1 mmm /	(dann		17/6	5735		SMRM	bon 22/1998	
10		30. Name and address of person who con from the first from the fir	ompleted cause of deeth			num sim			BNNMWE,	
St	ate	31. Dele filed (Marth Day, Year) 100	32. Registrer's S		Span				17.31	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month **Physician** Esther Drayer September 20, 1998 7:57 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Prince George's Regional Laurel Laure If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 17,1913 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Min. Hours 1□M 2QF 203-24-0547 85 Pennsylvania Director **Usual Residence of Decedent** with the Meryland 10e. State 10b. County 10c. City, Town or Location pernit. Pages 1 and 2 ahould be filed within 72 hours after deeth with the Merylan Department of Health and Mentel Hygiene. Important: if Item 27 ie marked other than "natural", or Items 23a or 28a-f ehow any Injury or other treumatic event, the Medical Examiner must be nounted. 10d. Inside City Limits HE Yes 2□No Director Venango Rouseville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Main Street 16314 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Yes 2 No
If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: P 3. Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Florist Flower Shop 17 Father's Name /First Miridle Last) 18. Mother's Name (First, Middle, Maiden Sumame) 89 Samuel E. Clark Liddie S. Yates 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 205 Third Street, Rouseville, Pennsylvania 16344 Patricia Lamb/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Grove Hill Cemetery 9/24/98 Oil City, Pennsylvania 21. Signature of Funeral Segrice License 22. Name end Address of Fecility
Fleck Funeral Home, Inc.
7601 Sandy Spring Road Laurel, Maryland 20707 Furth. Enter the discuss, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) MYOCARDIAL INFARCTION /Medical HOURS Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. agned by to be detact 1 Yes 2 No 3 Probably 4 1 4 thknown HY BERTENSION þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1□ Yes 2BNo 1 Yes 2₽No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation death. 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Descripting Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Ulin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

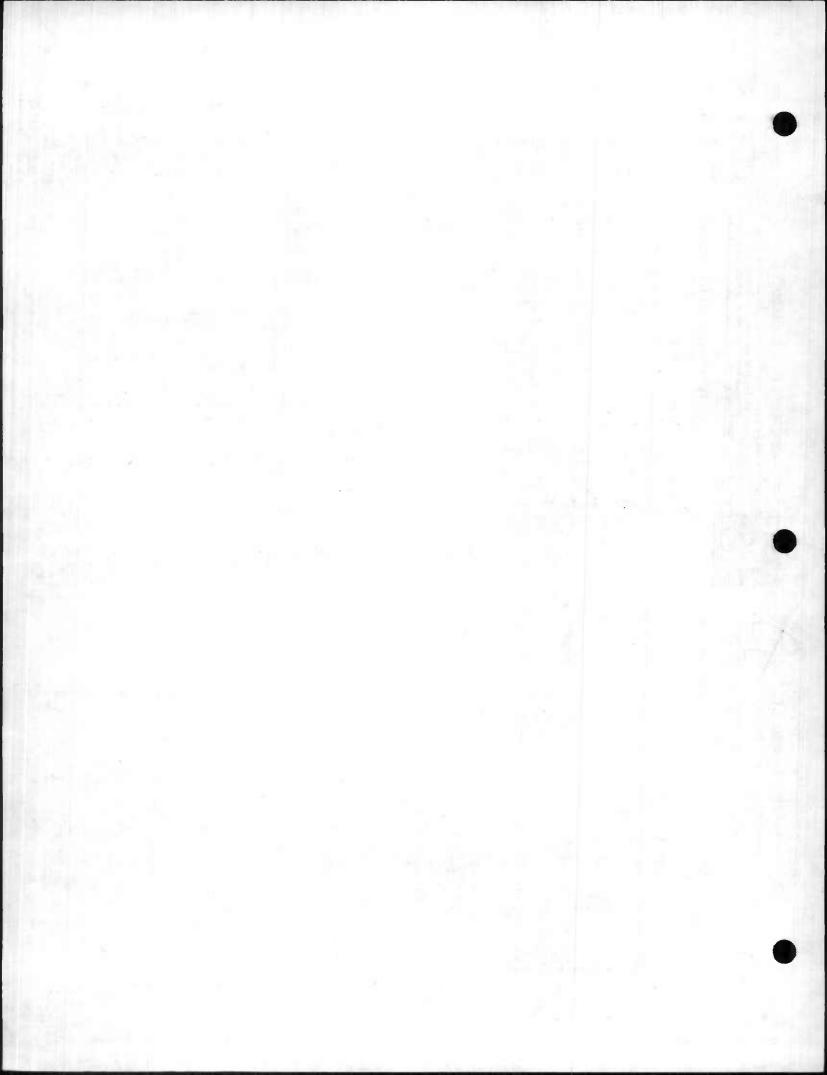
32. Registrar's Signeture

1000

31. Date filed (Month, Day, Year) SEP 2 5 1998

LUIS A. CASAS

8317 CHERRY LANE LAURER MIX 20707



Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at page.

Physician

/Medical

Examiner

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page 2

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cartificate Physician:

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hin 24 hours after the Funeral Dire mpletely filled in b Hospital

vithin 2 To the F

2 Director

3

al or Attending P Athar

altimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

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State of Maryland / Department of Health and Mental Hygiene

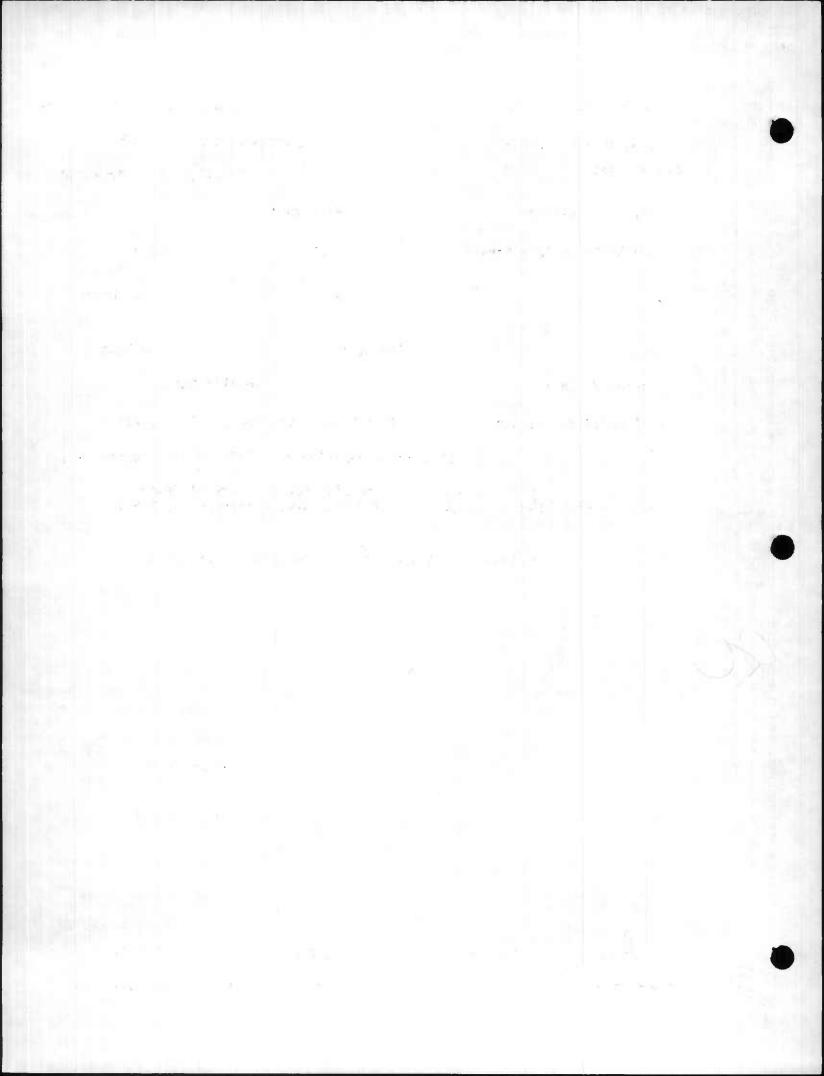
Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth **Physician** ANNA Μ. FLYNN SEPTEMBER 23, 1998 1004AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 800 SOUTH BOULDIN STREET BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Deys Hours 1 M 2 XF 214-26-2929 Yrs. 70 Maryland Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits Md. Baltimore Baltimore 1 □XYes 2 □ No Director 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 21224 800 South Bouldin Street USA Funeral 12. Wes Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Stetus Bleck, White, atc. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Homemaker own home 5th 18. Mother's Name (First, Middle, Maldan Sumeme) 17. Fether's Neme (First, Middle, Last) Be Rosalie Smith Charles Waddell 19b. Melling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) WilliamJ.FlynnJr./son 8 Hollybrook Court Perry Hall MD. 21217 20b. Placa of Disposition (Neme of cemetary, crametory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1XXBurial 2 ☐ Cremetion 3 ☐ Removel from State GlenHavenMemorialPark 9/26/98 Glen Burnie 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221
Do not enter the mode of dying, such as cerdiac or respiratory arrest. 23a. Part1. Enter the diseese, or companion, or heert feilure. List only Approximete Intervel Between Onset and Deeth Immedieta Ceuse (Final diseese or condition resulting in deeth) Atheroscleration ardiovascular Due to (or es a consequence of) Examir Sequentielly list conditions, if eny, laading to immadiata cause. Enter Underlying Cause (Diseese or injury that initiated avants resulting in death) Lest Due to (or as e consequança of): edical Due to (or es e consequence of): Physici 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably WUnknown þ 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes an autopsy performed? Completed INSPECTION 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical exeminer? Be 26. Plece of Deeth (Check only ona) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 ☐ Nursing Home 5 N Residence 6 ☐ Othar (Specify) To 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. fnjury at Work? Certification: 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 6 Could not be determined 28e. Placa of Injury - At homa, farm, straat, fectory, offica building, etc. (Specify) 3 ☐ Sulcide 4 Homicide 29a. Certifier 1 Cartifying Physician: To the bast of my knowledge, deeth occurred at tha tima, date and placa, end due to the cause(s) and menner es stated. edical 2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) end manner stated. (Check only one) 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. SEPTEMBER 23, 1998 30. Nema end eddress of person who completed cause of daath (Item 23a) (Type, Print)

Dennis Chute M.D. 31. Date filed State

111 Penn Street, Baltimore, Maryland 21201

32. Registrer's Signature

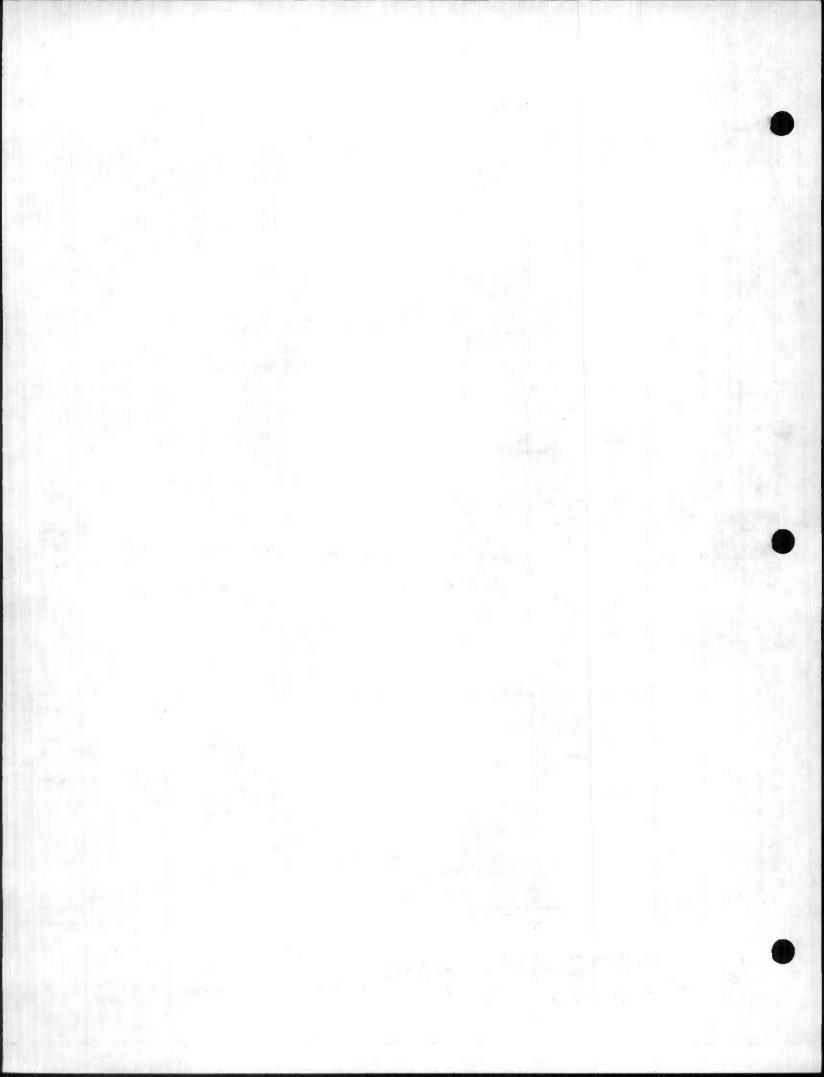
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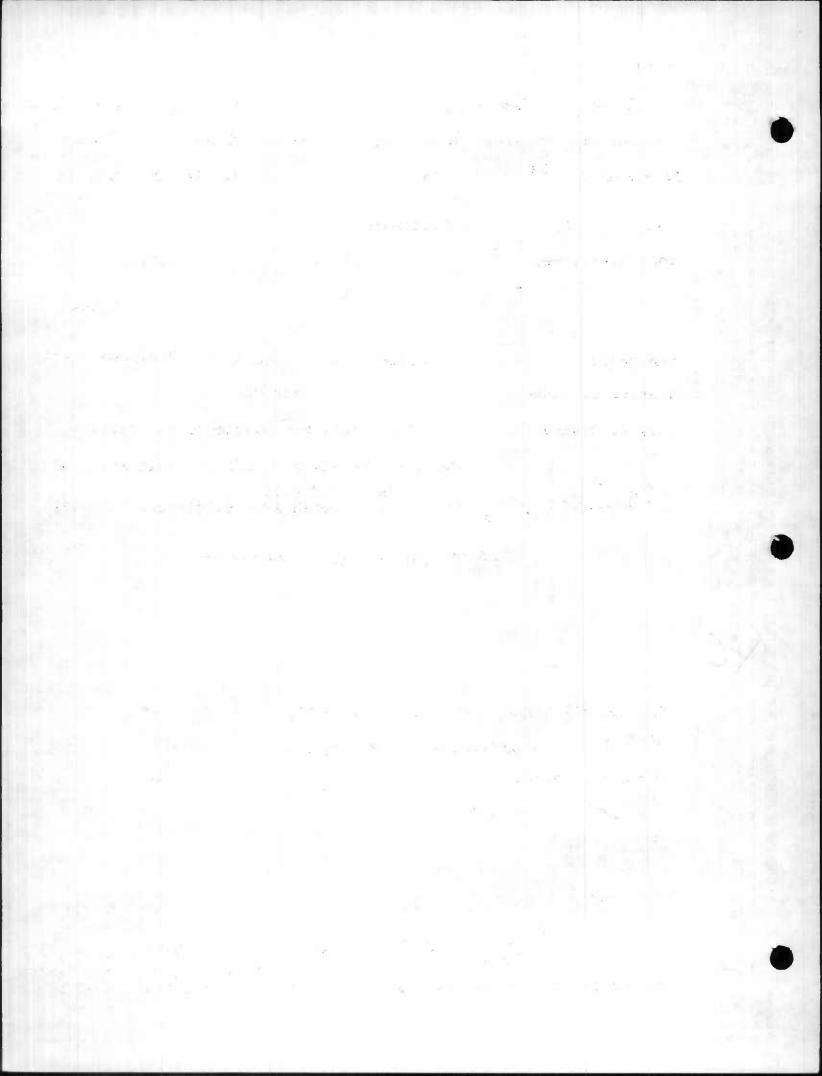
State of Maryland / Department of Health and Mental Hygiene

					C	ertifica	e of	Death			Reg. No.) (7401
	_	1. Decedent's Name (First, Middle, L	ast)							2. Date of De Month		Veer	3. Time of Death
Physiciar Medica/	d	James Joseph Fo								Septemb	per 16,1	998	3:20 P.N
Examine		la Facility Name (If not institution, gi 2206 Ridge Road		umber)				4b. City, To Wood1		ocation of Deat			County
Funeral Director		215-07-4080	Sex 1∏M 2□F	7. Age (In) 82	yrs. last birthdi Yrs	Months			24 Hrs. Min.	8. Date of Bir (Month, Da DEC . 5 ,	th ay, Year) 1915	9. Birthple Country Mary.	ce (Stete or Foreign Land
Maryland 4 ahow		Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	re		City, Town or		n 1					100	d. Inside City Limits
ter deeth with the Marylan flerna 23a or 28e-f ahow foar must be nouthed at	5	10e. Street end Number 2206 Ridge Road				10f. Zip Code 21244-1032					10g. Citizen of What Country?		
or all	Dy rur	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	Amed F	2 □ No	n U,S. 1	3. Was Dece If Yes, spe	city Cul	ban, Mexicar	igin? (Sp n, Puerto	pecify Yes or No Plican, etc.)		ce - American ck, White, et by:	te.
	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	rade completed, College	(1-4or 5+)		cedent's Usu ive kind of w b. DO NOT u			t of worl	king	16b. Kind of B		
d oth	9	10 17. Father's Name (First, Middle, Las		A	Comm	ercial	Dr	18. Mothe			Transpo	me)	on
D = N =	0	James Joseph Fowler Ruth Cleveland Zipg 19e. Informent's Neme/Relationship (Type, Print) Ruth Stirn Fowler (wife) Ruth Stirn Fowler (wife) Ruth Cleveland Zipg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 2206 Ridge Road, Woodlawn, Maryland									, State, Zip C		
T T B	520	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State											
Porte		4 □ Donation 5 □ Other (Specify) Lake View Memorial Park 9/19/98 Eldersburg, Maryland 21. Signature of Funerel Service Liouve Loring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, MD. 21133											
Physician /Medical		23a Park Enter the disease, or the shock, or heart leiture. List can find the shock of the shock	nplications that y one cause on	caused the deach line.	leath. Do not	enter the mo	de of dy	ing, such as	cardiac	or respiratory a	rrest,		Approximate intervel Between Onset and Death
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at the death or d by the attend stached for us	1 310	Part II. Other significant conditions	contributing to c	seath but not	resulting in th	e underlying	ause g	iven in Part I	1.	23b. Did	tobacco use co	ontribute to t	the cause of death?
that deb										10	Yes No	3 Proba	ably 4 Unknow
aw requir	Deteidu										an autopsy ormed?	com	e autopsy findings lable prior to spletion of cause eath?
certificate har rector, page								1 - 12		10	Yes 2 No	10	Yes 2 No
		25. Wes case referred to medical examiner? 1 ☐ Yes ②ONO	Hospital:	les-sels-sels-sels-sels-sels-sels-sels-		e ma	. 0	ther		th (Check only			
Attending Physics of Gath. ecfor: After this by the funeral di	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mor	Inpatient : of Injury oth, Day Year	2 ER/Outpa 28b. Time Injur		28c. Inju	4 LI NO		-	idence 8 Ot how injury occu		
is after death. In Director, After ted in by the funerical constitution.		3 ☐ Suicide 6 ☐ Could not determined	be d 28e. Plec build	e of Injury - A ting, etc. (Sp	kt home, lerm, ecify)	street, factor	y, office			28f. Location (City or To	Street and Num wn, Stete)	ber or Aurel	Route Number,
he Hospi in 24 hou he Funer pletely fill	Polical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	miner: On the b	e best of my pasis of examiner stated.	knowledge, de ination and/or	eath occurred investigation	at the t	ime, date an opinion, dea	d place	, and due to the rred at the time,	cause(s) and m date and place	anner as sta , and due to t	ted. the cause(s)
To th within		29b. Signature and title of certifier	huje	io				F780	,)		29d. Date signe	198-	ay, Year)
6		ALEMNORO ON	ESIA B	ud .	(Typ)	Fueli	wi	t	do	- Ball	linere	2122	28
State	1	31. Dele liled (Month, Day, Year)	32.1	Registrarts Si	gnature	6	1	*					



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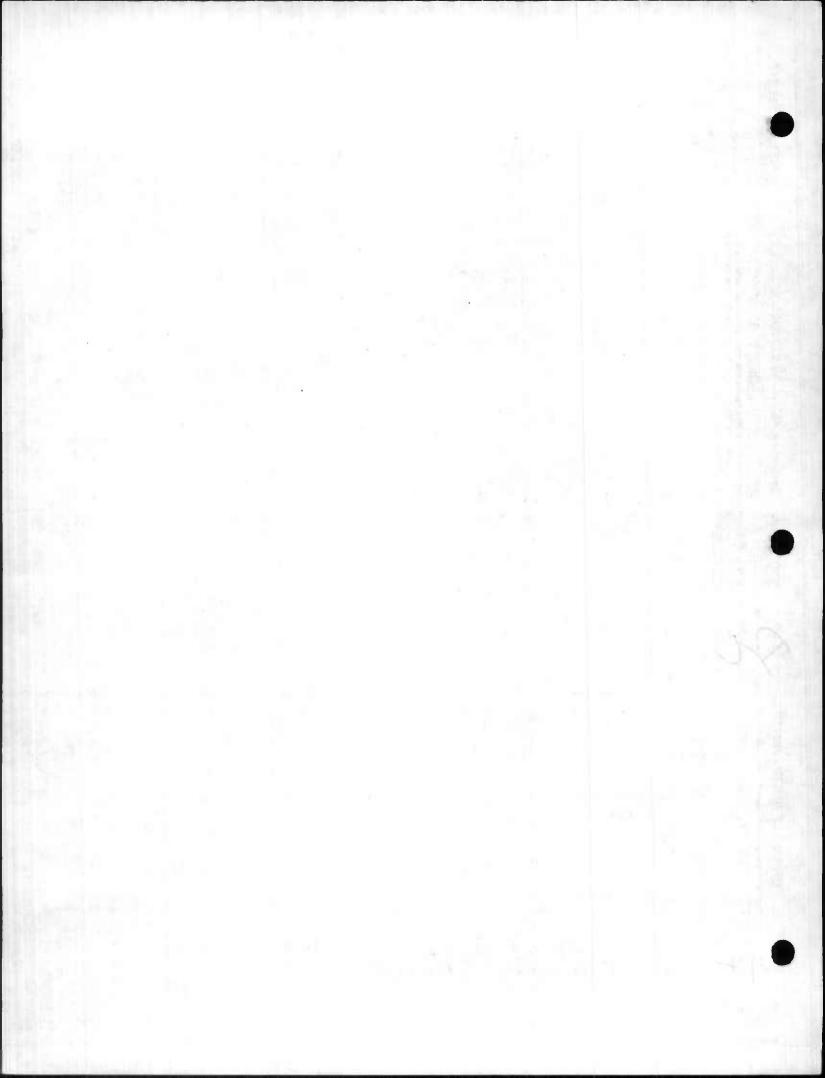
Per FH Film G764 10-1-98R		ryland / Dep Ce	ertificate of			Reg. No.	29462					
1. Decedent's Name (First, Middle, Last					2. Dete of De Month	eth Dey	3. Time of Deeth					
VESSE	GRAN	D4			SEPTER		1988 11 33					
4e Fecility Neme (If not institution, give NONTHWZST HS		Conto		2 AUD ALL		-	Tinent					
5. Social Security Number 6. Se	0	(In yrs. last birthde			8. Date of Bir	th	9. Birtholece (State or Foreign					
	MM 2□ F	76 Yrs.	Months Deys	Hours Min.	(Month, De	y, Year) 8 21	Country) M • D •					
Usual Residence of Decedent												
10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits 1X Yes 2 □ No					
MD NA		Baltim	ore 10f. Zip Code			10g. Citizen of W						
	CIRCLE											
7801 Carmel Ct. 1. Maritel Stetus	12. Was Decedent 8	Ever in U,S. 13	. Was Decedent of	4 Hispenic Origin? (S ban, Mexican, Puerl	pecify Yes or No	U.S.A 14. Reca	- American Indian,					
1 Never Married 2 Married	Armed Forces? 1X Yes 2 N If Yes, Give	lo	If Yes, specify Cui		o Rican, etc.)		k, White, etc.					
3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		TILI TOS ÆRZAVO	э эрвспу.		Specify:	Black					
15. Decedent's Edu (Specify only highest grad		(Giv	edent's Usuei Occu	during most of wo	rking	16b. Kind of Bu	siness/industry					
Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retir			Pothl-	hom Stool					
6th Grade 17. Father's Name (First, Middle, Last)	NA	Mate	rial Ro	om Atte	ndant ne (First, Middle	, Meiden Sumem	hem Steel					
Charles E. Gran	vbn			Mary C	hase							
19e. Informant's Name/Relationship (7)		19b. Ma	ling Address (Stree	et end Number or Ri		er, City or Town,	Stete, Zip Code)					
Mary E. Grandy		7801	Carmel	CIRCLE Ba	ltimor	e Md 2	1244					
Mary E. Grandy 20e. Method of Disposition 1 XBurial 2 Cremation 3 F	Removal from State	20b. Plece of Dis	position (Name of emetory or other pl	ece)	Date	20c. Location -	City or Town, State					
4 ☐ Donetion 5 ☐ Other (Specify)		Woodlav	n Cemet	ery	9/28/9	8 Balti	more, Md					
21. Signeture of Funeral Service Licensee 22. Name and Address of Facility March F/H West												
23e Part Enterthe disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory errest. Approximate												
23e. Part1. Enterine disease, or complications that occused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Appropriate the mode of dying, such as cerdiac or respiratory errest, Interview												
Immediate Ceuse (Finel	24 me.											
disease or condition resulting in deeth)	a. Alan	Due to (or es a cons	MONTHUM PRINTERS	, EMB	Dusm							
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Sequentially list conditions,	0.	Due to (or as a cons	equence of):									
f any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury	C						1 1 10					
Ihat initieted events resulting in deeth) Last		Due to (or as e cons	equence of):									
	d											
Part II. Other significant conditions con	ntributing to death by	It not reculting in the	underlying courses	niven in Part I	23h Did	tobacco use con	atribute to the cause of death?					
						Yes 2 NHO	3 Probably 4 Unknown					
TENTE ITTUE	1	06.16	TARE	oue.								
RENAL FAILLE ACIDESIS; BIABLTIS MA	Myports	Direct 1	NEASO	TEAN	24e. Wes	en autopsy ormed?	24b. Were eutopsy findings evalleble prior to					
24	100110						completion of cause of deeth?					
BIABETIS ME	Wites				10	Yes 20 No	1 ☐ Yes 2 ☐ NO					
25. Wes cese referred to medical examiner?	Hospital:			Whor	ath (Check only							
1 ☐ Yes 25 M6	1 Lumpatie		ent 30 DOA		_	how injury occurr						
1 ☐ Matural 5 ☐ Pending	28e. Date of Injur (Month, De)	Year) Zoo. Time	W	ork? □ Yes 2 □ No								
3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, farm,			28f. Location	Street and Number	er or Rural Route Number,					
4 Homicide	building, efc	. (Specify)			Uny or To	wn, Stete)						
	sician: To the best of						nner es stated. and due to the ceuse(s)					
one)	and manner sta				urred et trie time,							
29b. Signeture end title of certifier	00	1 >		nse number			d (Month, Day, Year)					
	(Xelen)	> mo	01	2502		Sintemi	301 23, 1978					
30. Name and address of person who co			e, Print)	A	ONTHW	rsy Hos	201 23, 1978 11746 CENTER 21133					
ORIANDED B.		or's Signature	1	* XWXII	STOWN	red	2/133					
31. Date filed (Month Day, Year) 199	N OZ. MOUISILE	a pargradura	· popou	2								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Decedent's Neme (First, Middle, Last)		Certificate	of Death	2. Dete of De	Reg. No.	3 Tim	a of Deeth					
Physician /Medical	Manley Howell Gri	swold		14.02.7	Septemb	per 23,	1998 10	0:30 P					
Examiner	4a Facility Name (If not Institution, give s Genesis Eldercare-		er	Baltimo	Location of Death	4c. Count	y of Death						
Funeral Director	214-18-0529	7. Age (In yrs. k	Yrs. If Under 1 Months	Year If Under 24 Hn Deys Hours Mir		y Year) 1921	9. Birthplace (Ste Country) Maryland	ite or Foreig					
show show ad at	Usuel Residence of Decedent 10a. Stete 10b. County		, Town or Location					le City Limits					
vih the Ms r or 28e-f r be notifie Directo	Maryland N/A 10e. Street and Number	Bal	timore 10f. Zip C	ode		10g. Citizen of	What Country?						
			2121			U.S.A.							
020 urs after death v et; or thems 23s Examiner mant by Furneral	3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U,S Amed Forces? 1 ⊠ Yes 2 □ No If Yas, Giva Year or Dates: WW II	13. Was Deceder	nt of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)	Bla Specil	ce - American Indiar ick, Whita, etc. 'Y: White	1,					
Maryland 21215-0020 d2 should be filled within 72 hours at the and Markell Hygiens for the and factorial progression of the marked other than "natural; or traumetic event, the Medical Exam. To Be Completed by §	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 Years 6	completed) College (1-4or 5+)	16a. Decedent's Usual (Giva kind of work life. DO NOT use School Teac		Baltimo	ore City Schools							
/land 2 /land 2 /land 2 /land 2 /land 3 /land	17. Father's Name (First, Middle, Last) Philip Griswold	rear 3	School Teac		Meiden Sume								
	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Donald P. Griswold (Son) 20a. Method of Disposition 1 \(\omega \) Burial 2 \(\omega \) Cremetion 3 \(\omega \) Removel from State												
Baltimore, amit. Paper 1 a Separtment of Hea mportant: if Item; my Injury or othe mos.	4 Donation 5 Other (Specify) 21. Sign turn of Forest Service License												
Physician /Medical Examiner	Immediate Cause (Finel disease or complication) and complete Cause (Finel disease or condition resulting in death) b.	Diorbete Due to lor Hyperste					Approxi Intervel Onset e	Between and Deeth					
	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or	as a consequence of):										
that the death of the death of the death of the attending detached for used.													
The law requires the law requires the law requires the page 2 should be completed by					24a. Wes perfo	en eutopsy ormed?	24b. Were eutop available pr completion of death?	rior to					
Vita felan: cartific medior,	25. Wes case raferred to medical examiner?	ospital:		26. Place of Do	eeth (Check only	one)							
Division of Vital or Attending Physician; T sther death. Director, Altar this certificat d in by the funeral director, p	1 Yes 2 No	1 Inpatient 2 LE	ER/Outpatient 3 DOA 28b. Time of Injury M	4 Vursing Linjury et Work? 1 Yas 2 No	Home 5 Rasidance 6 Othar (Specify) 28d. Describe how injury occurred								
Division of the control of the contr	3 ☐ Suicide 6 ☐ Could not be detarmined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, factory,	office	28f. Location (City or To	Street end Num wn, Stete)	ber or Rural Route i	Vumber,					
the Hospi hin 24 hou the Furse npistaly fill Aedical	(Check only 2 Medicat Examinone)	cian: To the best of my know er: On the basis of examineti and menner stated.	on end/or investigation, in	my opinion, death occ	e, and due to the curred at the time,	data and place	, and due to the cau						
To To To Manage	29b. Signetura end titla of certification	1=	D 29c. 1	31464		S/2	ed (Month, Day, Yea	ir)					
10	30. Name and address of person who cor SHOA/13 A . HA	SHm) 821	23a) (Type, Print) N. ENF	m Smt	30€	Balt.	mD 21	201					

State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #19a Per FH Film G763 9-25-98RC Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Month **Physician** Phila Sept /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Health Belair Belair Harford Mariner If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5 Sociel Security Number Birthplece (State or Foreign Country) 6 Sex 7. Age (In yrs. lest birthday) **Funeral** 1□M 2□F Months Yrs. 215-28-8917 91 2/23/1907 Mississippi Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Depertment of Heelth and Mental Hygiane. Important: If item 23 to reserved other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mangal Example and the motillad a 10e Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD N/A Baltimore 10f. Zip Code 21206 10e. Street end Number 10g. Citizen of Whet Country? 4512 Woodlea Avenue U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 23∑ No If Yes, Give Yeer or Detes: 14. Reca - American Indien, 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Catherina Sasada Peter Frederick 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Edwin N. Giziniski Gizinski 4512 Woodlea Avenue Baltimore, Maryland 21206 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State Garden Faith Cemetery 9/26/98 Balto. Maryland of 4 ☐ Donetion 5 ☐ Other (Specify) John C. Miller Inc. 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, Maryland 21206 thomas Buanta 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician Immediete Cause (Finel diseese or condition resulting in death) /Medical month Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of) Due to (or es e consequenca of): Physician/M 23b. Did tobacco use contribute to the cause of deeth? Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 Probably by 24b. Were eutopsy findings evallable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 2 No 25. Wes case referred to medical exeminer? 89 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) Certification: 1 Neturel 5 ☐ Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Division Attending 6 24 hours Funeral within 2 8

> State Registrar

edical

29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end manner steted. 29c. License number

29d. Date signed (Month, Dey, Year)

034652

September, 24.

30. Name and address of person who completed cause of death (Item 230) (Type, Print)

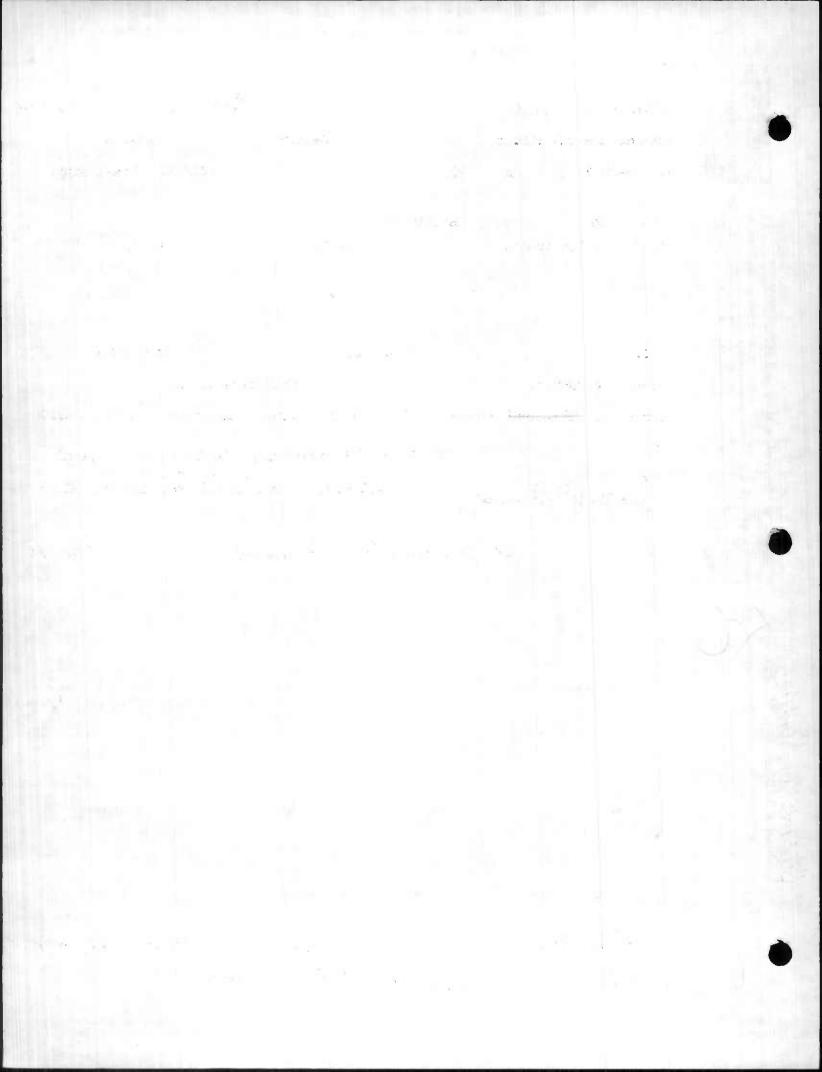
Seath Huswill 2 Marth Avinus Bil Air Marylund 21014 Avinul

31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier

2 5 1998

32/ Registrer's Signeture



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State of Maryland / Department of Health and Mental Hygiene Amend: #7 Per FH Film G763 9-25-98RC Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1 Decedent's Name (First Middle Last) 2113 **Physician** 4b. City, Town, or Location of Deeth Martha Elinor Hart /Medical 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner | Baltimore | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Oct. 31, 1924 St. Agnes Hospital 5. Sociel Security Number 7. Age (In vrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 1□M 20 F 77 73 Yrs. Maryland 218-18-3380 **Director** Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or hams 23a or 28a-f show treumstic event, the Madical Examiner must be notified at 1 Nes 2 No Director Baltimore City Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21229 Funeral 820 S. Caton Avenue 14. Rece - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: White Specify: à 3 X Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 8 Homemaker Own Home 18 Mother's Neme (First Middle Maiden Sumame) 17. Fether's Neme (First, Middle, Last) 2 should be fi and Mental F Is marked off Cora Gerber Lewis Hands 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If flem 27 is m 19e. Informent's Name/Reletionship (Type, Pnint) 3024 Chenango Drive, Charlotte, N.C. 28212 Lewis H. Politowicz, Sr. / Son 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 N Buriai 2 ☐ Cremetion 3 ☐ Removel from State 9/22/98 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Hubbard Funeral Home, Inc. el Funeral Service Licensed 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer feilure. List only one ceuse on each line. Approximete Intervei Between Onset and Deeth Physician DAYS immediate Ceuse (Finei disease or condition resulting in deeth) /Medical SEPTIC SHOCK Examiner Due to (or es e consequence of): YEARS (CHRONIC RENAL FAILURE Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury YEARS CORONARY ARTERY DISE AST that initieted events resulting in deeth) Lest Due to (or es e consequence of) UE ARS NIDDM Box Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 m Unknown Records, à 24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed 1 ☐ Yes 2 No 1 □ Yes 2 □ No of Vital Be 25. Wes cese referred to medical 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. injury et Work? Certification: 5 Pending 1 Neturel 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steled.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) end manner stated. 29e. Certifier edical (Check only one) 29b. Signeture and title of contifier

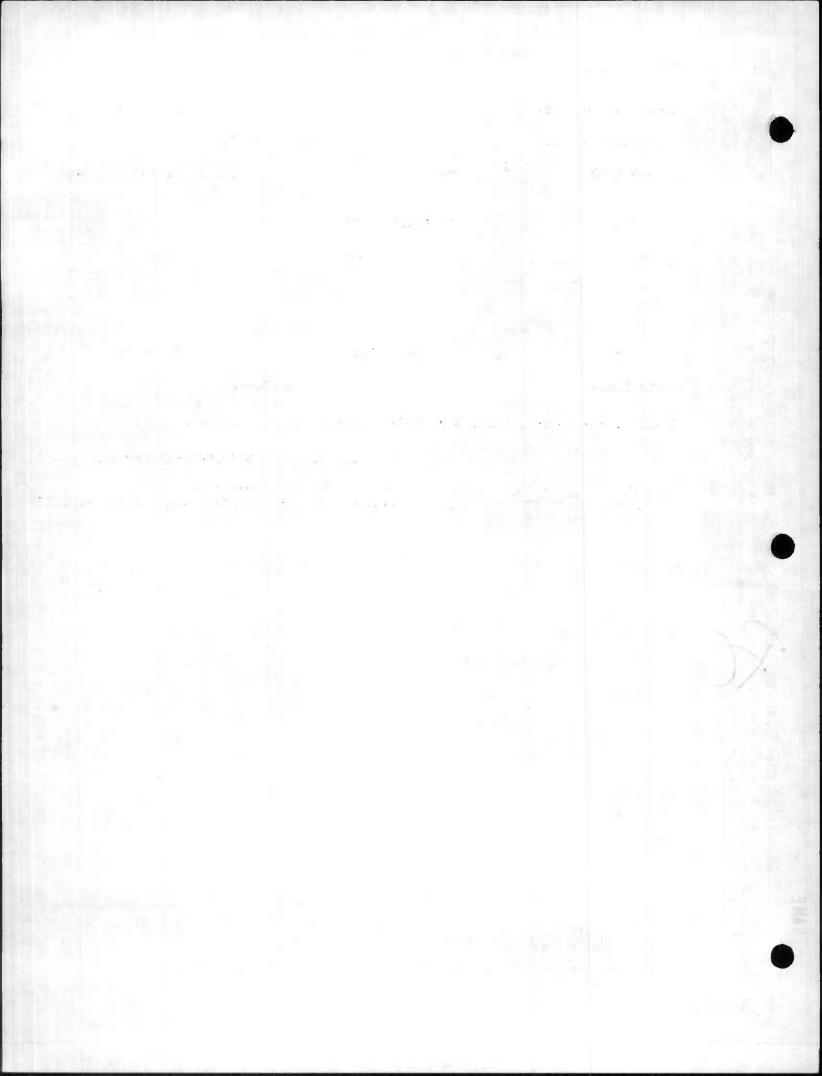
Nuclear Ollodius 29c. License number 29d. Date signed (Month, Dey, Year) SEPTEMBER - 18-1998 ST AGNES HOSPITAL 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) BALTIMORE 900 CATON AUE LUCIA PALLADINO 31. Dete filed (Month, Day, Yeer) SEP 2 5 1998 32. Régistrer's Signeture State Darks Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Florence Sept. Hodgson 21, 1058 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) March 27, 1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 M 2 F 75 Yrs. Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 Yes 2 XNo 10f. Zin Code 10g. Citizen of What Country? 9 High Button Court 21236 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Fecility

Bookkeeper

20b. Plece of Disposition (Name of cemetery, cremetory or other place)

Ulmonan

DUT

Due to (or es a consequence of):

Due to (or es e consequence of):

brain Surger

28b. Time of

Kelly

Director 10e. Street and Number Funeral 11. Meritel Stetus þ Completed Be

28e-f ò 238 or Berns filed within 72 hours after Pages 1 and 2 should be in ment of Health and Mental H ant: If them 27 is merked off lury or other transmatic even

Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral

Director

show

Alice

5. Social Security Number

216-12-9658

Maryland

10a. State

Usuel Residence of Decedent

3. Widowed 4 □ Divorced

15. Decedent's Education (Specify only highest grade completed)

Leslie

Year or Dates:

College (1-4or 5+)

Physician /Medical Examiner

icien and burial-transit physicien s the burial 98 080 signed by the a d be deteched f funeral director, Be After this To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

Examiner Physician/Medical þ Completed Certification: To

Medical 29b. Signature end title of certilier

1-Meturel 2 Accident 3 Suicide

4 Homicide 29a, Certifier

Elementery/Secondary (0-12) 12th Grade 17. Father's Neme (First, Middle, Last) William 19e. Informent's Neme/Relationship (Type, Print) Mark Hodgson 20e. Method of Disposition Buriel 2 Cremetion 3 Removel Irom State 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore,

23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieled events resulting in deeth) Lest Pert II. Other algriffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical exeminer? 1 Yes 2 No

27. Manner of Deeth

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

28a. Dete of Injury (Month, Dey Year)

Hospital: 1 ☐ Inpatien1 2 ER/Outpatien1 3 ☐ DOA

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number 037573

tiangle Cortifying Phyaician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year) 24,1998 Sept

30515

281. Location (Street and Number or Rural Route Number, City or Town, State)

White

Leutner

Approximate Interval Between Onset and Death

minutes

Specify:

Restaurant

18. Mother's Name (First, Middle, Maiden Surname)

Date

Victoria

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

Battime MD

1 Yes 2 No

28d. Describe how injury occurred

Mabel

9 High Bottom Ct., Baltimore, MD 21236

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Moreland Memorial Park 19/25/98 Baltimore, Maryland

16b. Kind of Business/Industry

20c. Location - City or Town, State

23b. Did tobacco use contribute to the cause of death?

1 Yes 25 No 3 Probably 4 Unknown

24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be determined

Zibell

SEP 2 5 1998

31. Date filed (Month, Day, Year)

necent

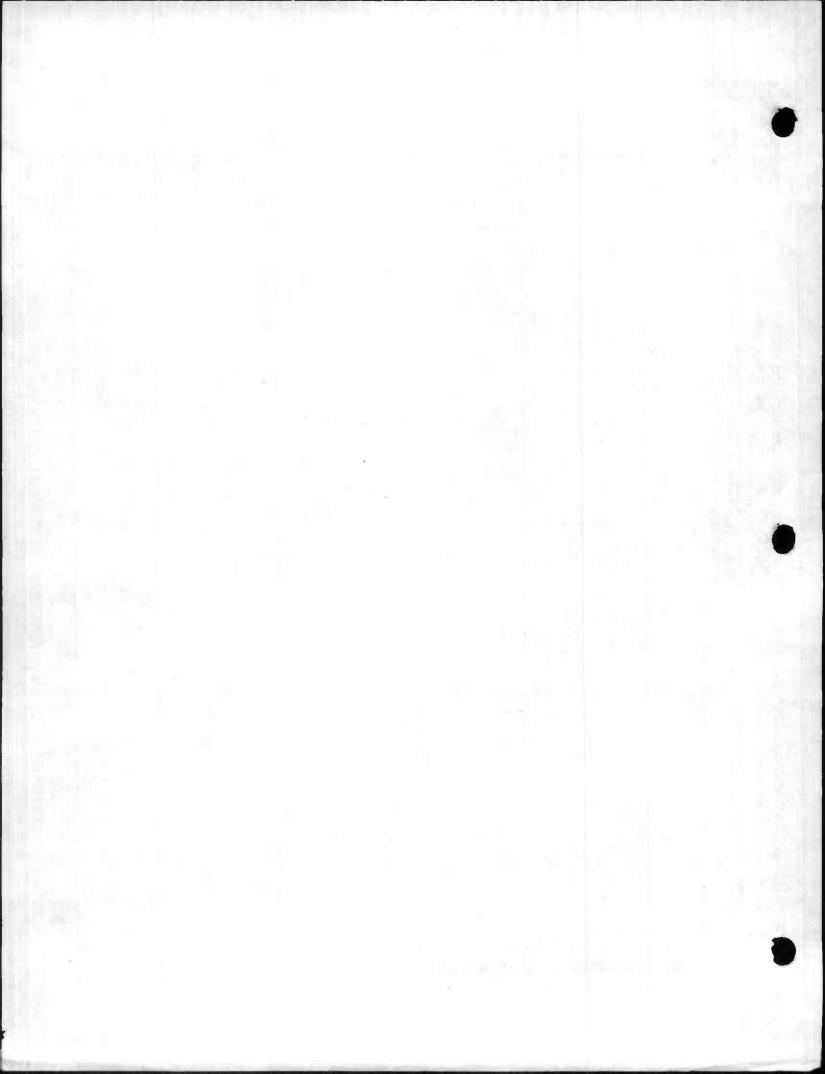
7220 Park MO 32. Registrer's Signeture

Deneva

DHMH 16 Rev 6/95

State

Registrar



MACHEL

Physician

/Medical

Examiner

5 Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2□ F 204 20 2861 70 Yrs. Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 28a-f show Director Prince George's Maryland 10e. Street and Number 10f. Zip Code 6 2601 Kennison Lane 20715 Items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: natural, or by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent'a Education (Specify only highest grade completed) filed within 7 I Hygiene. other than *r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 marked other 17. Father's Name (First, Middle, Last) Be end Mental John Livingston 19a. Informant's Name/Retationship (Type, Print) Depertment of Health end Important: If item 27 is m any injury or other traumonce. Maurice A. Herron Husband 20a. Method of Disposition Buriel 2 ☐ Cremation 3 ☐ Removei from State

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Margaret C. Herron 9:07 PM SEPTEMBER 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Doctors' Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Dec. 28,1927 Pennsylvania 10d. Inside City Limits XXX Yes 2 No 10g. Citizen of What Country? United States 13. Was Decedent of Hispento Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No Specify: Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) Mary Ritchie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 Kennison Lane Bowie Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 26, 1998 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens Davidsonville MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): brainstem Stroke Due to (or as a consequence of) Due to (or as a consequence of)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician /Medicai Examiner

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certificate

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To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral

within 24 hours e To the Funeral D

funeral

Box 68760,

P.O. 1

Records.

Division of Vital

Examiner

Physician/Medical

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Completed

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Certification:

Medicai

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part ti. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i.

23b. Did tobacco use contributa to the cause of death? 1 Yes 2⊠ No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings eveitable prior to completion of cause of death?

1 ☐ Yes 2 🗷 No 26. Place of Death (Check only one)

1 Yes 2 No

25.	exeminer?
	1 Yes 2 No
27.	Manner of Death

1 Watural 5 Pending investigation 2 Accident

28a. Date of Injury (Month, Day 6 Coutd not be determined 28e. Place of Injury - At home, falm, street, factory, offica building, etc. (Specify)

Hospital:

2 ☐ ER/Outpatient 3 ☐ DOA 28h Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

281. Location (Street and Number or Rurel Route Number, City or Town, State)

29a, Certifier

3 Sulctde

4 Homictde

12 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end titte of certifier

29c. License number

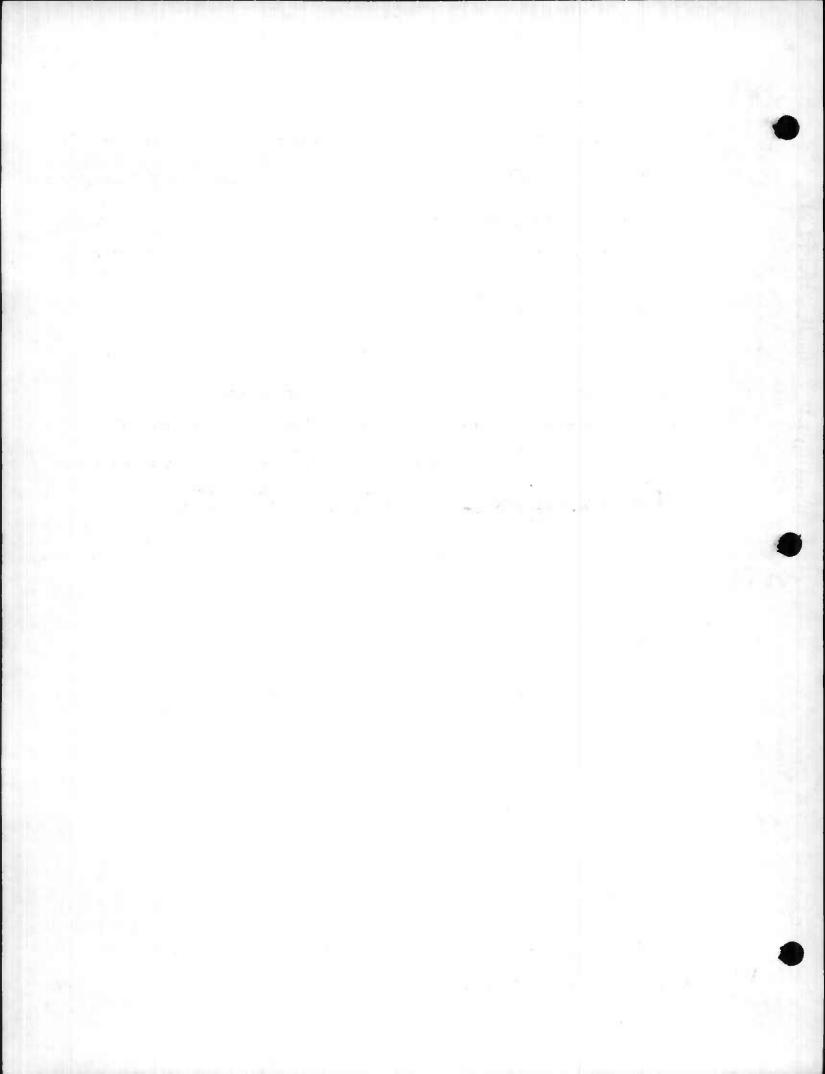
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ratur Falor 12.0

ROINTAN FARAHIFAR n.D. 4000 Mitchelle ville road BUG BOWIE MOZONK 31. Date filed (Month, Day, Year) SEP 2 5 1998

State Registrar \$2. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middla, Last) September 20, 1998 ear Anna Rosalie Hokemeyer 5:45 a.m. 4a Facility Name (If not Institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death 4561 Shanklin Road White Hall Harford 5. Social Security Number If Under 1 Year | II Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) Sex 1□M 2□F Months Days Hours Min 78 Yrs. 219-01-6270 October 16, 1919 Baltimore, Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Maryland Harford 1 ☐ Yes 2 ☐ No White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4561 Shanklin Road 21161 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NA Housewife Housekeeping-Own Home 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Oswald Herman Gebler Mary M. Naseman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gretchen Shanklin (Daughter) 4561 Shanklin Road White Hall, Maryland 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 💆 Cremation 3 ☐ Removal from State 4 Donetion 5 Other (Specify) Metro Crematory, Inc. September 23, 1998 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lassahn Funeral Home, Inc. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Asshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio Pulmonary Immediate Cause (Final disease or condition resulting in death) Congestestive Heart Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contributs to the cause of death? Alzheimer's Disease 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings eveilable prior to completion of ceuse of death? Parkinsin's Disease 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 Yes 26. Place of Death (Check only one) Hospital: 5 Residence 6 □Other (Specify)

Physician /Medical Examiner

b

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

the marked other than "natural", or items 23a or 28a-f show renmatic avant, it a Mod call Examiner must be notified at

nemil. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "natural", or frems 23

Baitimore, Maryland 21215-0020

with the Maryland

Examine and attending physician for use as the buria Physician/Medical

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Completed

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Certification: To

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The law requires that the death certificate be executed the signed by t page 2 certificate Attending Physician: director, this After thi Director:

within 24 hours a To the Funeral D

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Division of Vital Records, P.O. Box 68760,

25. Was cese referred to medical examiner? Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No **₽** □ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one)

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of confi

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Sept-21-98

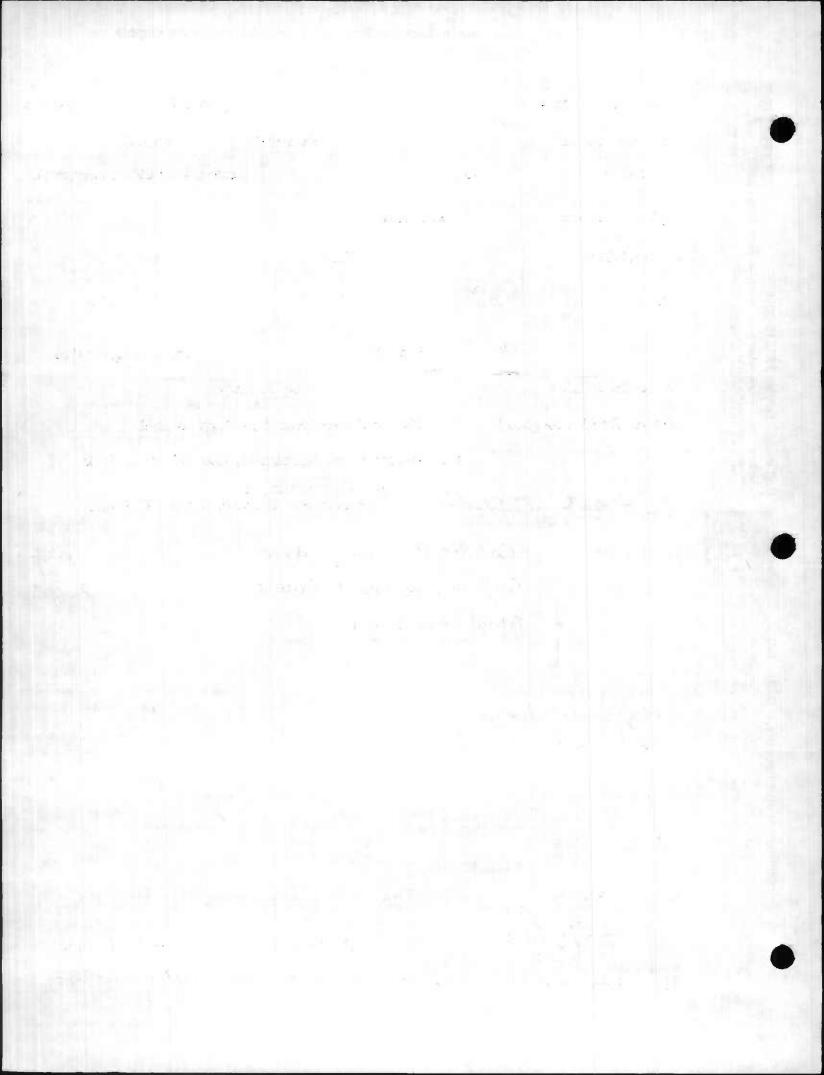
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FALLSTON MD 21047 ROAD HARFORD D. PAREKH MD. 1908 31. Date filed (Month, Day, Year)

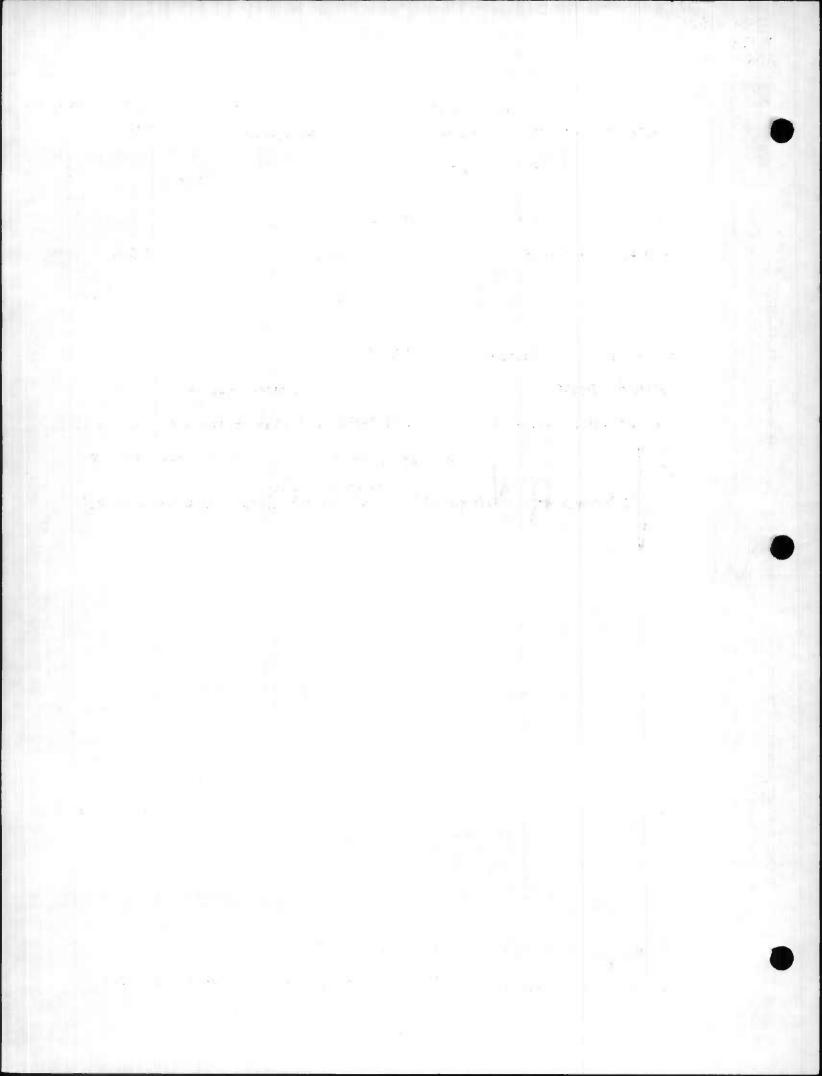
State Registrar

2 5 1998 SEP

32. Registrar's Signature



	02	Items: 23 part I,II,27		763 10	/1/98Ces	tificate	of He	Death			leg. No.		146	9
hysici	an	Decedent's Name (First, Middle, Las								2. Date of Dee	Day	Year	3. Time o	
/Medi	cal	4e Facility Name (If not institution, give	Carl I		ner		41	o. City. Tow	vn. or Lo	SEPT.	17, 199 4c. County		0930	MA C
xamir	ner	3124 OAKFORD AV	ENUE - V	ACANT	HOUSE			BALTI			N/	A		
neral ector		220-64-8022	ex OXM 2□ F	ge (In yrs. 42	lest birthday) Yrs.	If Under 1 Months C	Year Deys	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 4-18-	7, Year) 1956	9. Birthpie Countr	Md	or Foreign
A 11		Usual Residence of Decadent 10e. Stete 10b. County		10c. Cit	ty, Town or Loc	ation						100	d. Inside C	Ity Limits
Fled	tor	Md	N/A	В	altimo	re						4	1 Yes	2 No
or 28	Olre	10e. Street and Number				10f. Zip Co					10g. Citizen of V		y?	
	eral	4630 Pall Mall Ro		Funcia II	6 42 4		121		in? (Coo	aih. Van ar Na	U :	S A e - America	n Indian	
important; if item 2.7 is metiked other than inautial, or items 2.5s or 2.5s-1 show any injury or other traumetic event, the Medical Examiner must be notified at one.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Wes Decedent Armed Forces' 1 Tes 2 Tes If Yes, Give Yeer or Detes:	?		Yes, specify Yes 2X			Puerto	cify Yes or No- Rican, etc.)	Specify	ck, White, et	tc.	
atura ical E	ted	15. Decedent's Ed			16a. Deced	ent's Usuai (Occupa	tion	of more		16b. Kind of B	usiness/Indu	stry	
Mad	nple	(Specify only highest green Elementery/Secondery (0-12)	College (1-4or	5+)	life. D	ond of work of NOT use	retired)	uring most	OF WORK	ng				
ar Eg	Be Completed	11th grade	Unknown		Carp	enter		10 Mothor	de Name	/Eiret Middle	Priva Maiden Suman		omes	
> 0	Be	17. Fether's Name (First, Middle, Last) ISSAC T. Joyner								Dawson		10)		
metic	5	19a, Informent's Neme/Relationship (7	Type, Print)		19b. Mailin	g Address (S	Street e				r, City or Town,	State, Zip (Code)	
or trac		Deborah Smith- Mo	other		4630	Pall	Ma	11 Rc	oad	Baltime	ore, M	d 212	215	
r oth		20a. Method of Disposition	Bamaual from State		Placa of Dispos cemetery, crem			9)	1	Dete	20c. Location -			
5		Dolation 5 Other (Specify		Woo	dlawn	Cemete	ery		9-	-26-98	Baltimo	re, Mo	t	
any in		27 Signature of Funeral Servica Licen	11 7			Name and A								
= 00		23a Part Filler the disease, or companies of heart failure. List only of	t. Thon	Pou	m .	4300	Wab	ash A	Aveni	ue Bal	timore,	Md 2	1215 Approxime	
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iled in by		3 ☐ Sulcide 6 ☐ Could not be determined	28e. Plece of fr building, e	jury - At h tc. (Specia	ome, farm, stre	et, factory, o	office			28f. Location (5 City or Tox	Street end Numl yn, Stete)	per or Rural	Houle Nur	n <i>ber</i> ,
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_		11-1111	11 -1	13	5 MD		O.C.	M.E			SEPT.	18,	1998	
		MUNUVIII	VUUL											
		30. Name and eddress of person who d	completed cause of								yland 2			



98-5452-510

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

LAURENCE **JONES**

State of Maryland / Department of Health and Mental Hygiene

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Physician
/Medical
Examiner

Funeral Director

Physician /Medical

Baltimore, Maryland 21215-0020

Examiner To the Nospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicians Division of Vital Records, P.O. Box 68760,

bX

				Ce	ertitica	ate of	Death		Reg. No.		
1. Decedent's Nam			C~					2. Dete of D	Day	Yeer	3. Time of Deeth
Lawrence		Jones	•	•			th Ch. Town	SEPTEN or Location of Dee	BER 16,		4:40P.M.
		ve street and number	,						4c. Coun	ty of Deeth	
425 E.20t					. 911		BALTIN			n/a	
5. Social Security N 212-32-	5316	Sex 7.A XXX 2□F		61 Yrs.	Month	der 1 Year Is Days	If Under 24 H Hours M	in. 8. Date of Bin. (Month, D	3,1937	9. Birth Cou	place (State or Foreign intry) MD
Usual Residence of			140-04	. 7							
10a. State	10b. County			y, Town or I							10d. Inside City Limits
MD	n/a		В	alti	more						₹C €es 2 □ No
10e. Streel and Nur	mber				10f.	Zip Code			10g. Citizen of	Whet Cou	intry?
425 E.	20th S	t.				212	218		U	Sa	
11. Marital Status 1 Never Marri 3 Widowed	ied 2□ Married	12. Was Decedent Armed Forces 1	? No		If Yes, s	cedent of P pecify Cub 2000	lispanic Origin? an, Mexicen, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	BI	ece - Ameri eck, White	242
10	15. Decedent's E			16e. Dec	edent's U	sual Occup	ation		16b. Kind of	Business/fr	ndustry
(Spec	only highest gr	ade completed) College (1-4or	5+)	life.	DO NOT	work done use retire	during most of v d)	vorking			
8th	many (o'12)	Conaga (1º40)		Sol	oies	t			self	emp1	oyed
17. Father's Name	(First, Middle, Las	t)					18. Mother's N	lame (First, Middle	e, Maiden Sume	ime)	
Emery	Harris						Glad	lys Jo	nes		
19e. Informent's No				19b. Mai	ilina Addr	ess (Street	and Number or	Rural Route Num	ber, City or Tow	n, State, Zi	ip Code)
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(Amo	ali h	Into		- 1	1701	Lau	rens S	St. Bal	to., M	D 2	1217
Immediate Cause disease or condition resulting in deeth)	rt failure. List only Final	e. A News	ine.		xi	CA		cutor	,	1	Approximate Interval Between Onset end Deeth
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									s an eutopsy formed?	0	Vere autopsy findings vailable prior to ompletion of cause
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25. Was cese refer	red to medical						26. Place of D	Death (Check only	one)		
exeminer?	No	Hospitel:	ent 2	ER/Outpati	ent 3	DOA OI	ner: 4 Nursin	gHome 5 T√Res	sidence 8 🗆 O	ther (Spec	ify)
27. Manner of Deat	h 5 Pending Investigation	28e. Date of Inj (Month, D	ury	28b. Time Injury	of	28c. Inju Wo		41	how Injury occ		
2 Accident 3 Suicide 4 Homicide	6 Could not le	28e. Place of Ir	jury - At ho tc. (Specify				10.73	28f. Location City or To	(Street and Nur own, State)	nber or Ru	ral Route Number,
29e. Certifier (Check only one)		hysician: To the best miner: On the besis and manner s	of examinat								
29b. Signatire end	title of certifier					29c. Licen:	se number		29d. Dete sign	ned (Month	Dav. Year)

Registrar

person who completed ceuse of deeth (Item 23a) (Type, Print) Konzu un

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

SEPTEMBER 17,1998

TELES COL 12 대학자 및 12 대학교 및 기계 12 대학교 (12 대학교 기계 12 대학교 PARKET PROFESSION and statement was seen as the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Yaar Bridget M. Keehner Saptember 6:40 AM 1998 4e. Fecility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Death Charlestown Care Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foraign Country) 1 M 2 KF Days 275-32-2453 82 Yrs. Feb. 4, 1916 Ireland Usuai Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits Maryland Baltimore 1 ☐ Yas 2 ☐ No Catonsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 713 Maiden Choice Lane #4309 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No if Yas, Giva 13. Was Dacedant of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Biack, White, atc. 1 Navar Marriad 2 Married rr Yas, Giva Yeer or Datas: Specify: White 3 ₩ Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Collega (1-4or 5+) 6 Health Care Nursing Assistant 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Richard Murphy Bridget Drea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Eileen McEntee/Niece 3714 Glen More Avenue Baltimore, MD 21206 20a. Method of Disposition 12 Burial 2 Cremetion 3 Ramoval from Stete 20b. Place of Disposition (Nema of cemetery, crematory or other piece) Data 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 9/23/98 Baltimore, MD Gary L. Kaufman F.H. @ Meadowridge Mem. Park, Inc. 7250 Washington Blvd., Elkridge, MD 21075 Into the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, or haert failure. List only one ceuse on each line. Approximata interval Between Onset and Death PUTRACRANIAL immadlete Causa (Final diseasa or condition rasulting in death) BLEED 3 oday? Due to (or as e consequance of): Sequantially ilst conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated surgers) Dua to (or as a consequence of); that initiated evants rasulting in death) Last Dua to (or as a consequence of): Pert Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 201 No 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 27. Menper of Death 28d. Dascribe how injury occurred 28b. Time of 28c. injury at Work? 1 Neturei 5 Pending 2 Accident

dal-transit and **Physician/M** Division of Vital Records, P.O. à 2 Certification: death. after death Director:

Hospital 24 hours a Funeral D

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Name: 3 LIPLET

Physician

/Medical

Examiner

Funeral

Director

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Funeral

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the Marylend

death v

filed within 72 hours aftar

d 2 should be filed within the and Mental Hygiane.

permit. Pages 1 and 2 sh Department of Health and important: If Item 27 is m any injury or other traum

Physician

/Medical

Examiner

altimore.

25. Was case rafarred to medical examinar? 1 Yas 2 No

3 Suicida

29a. Cartifiar

4 Homicida

(Check only one)

Invastigation

6 Could not be datarmined

28a. Place of injury - At homa, farm, streat, factory, offica building, atc. (Specify)

1 ☐ Yas 2 ☐ No

28f. Location (Straat and Number or Rural Route Number, City or Town, Stata)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30 Nama and addrass of person who complated causa of death (Item 23e) (Type, Print)

29c. License number D26473 29d. Data signed (Month, Day, Year) September 25, 1998

Registrar

edicai

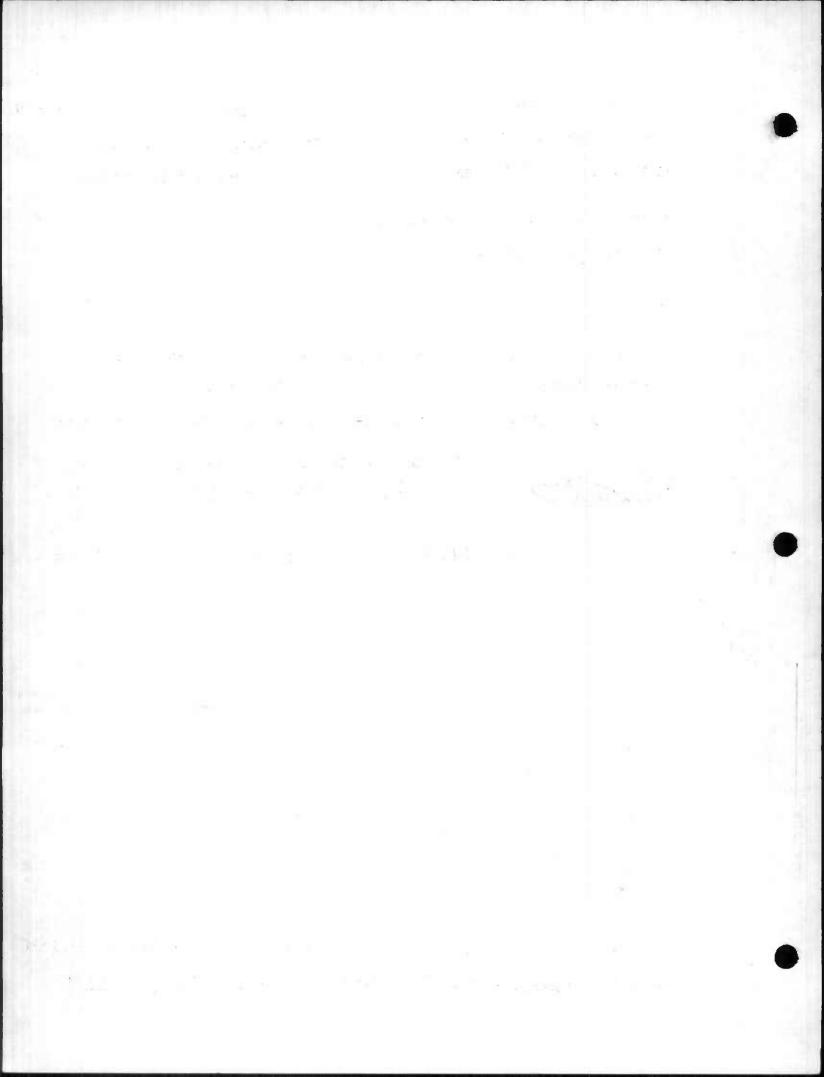
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711 MAIDEN CHOICELAND, 2/22X

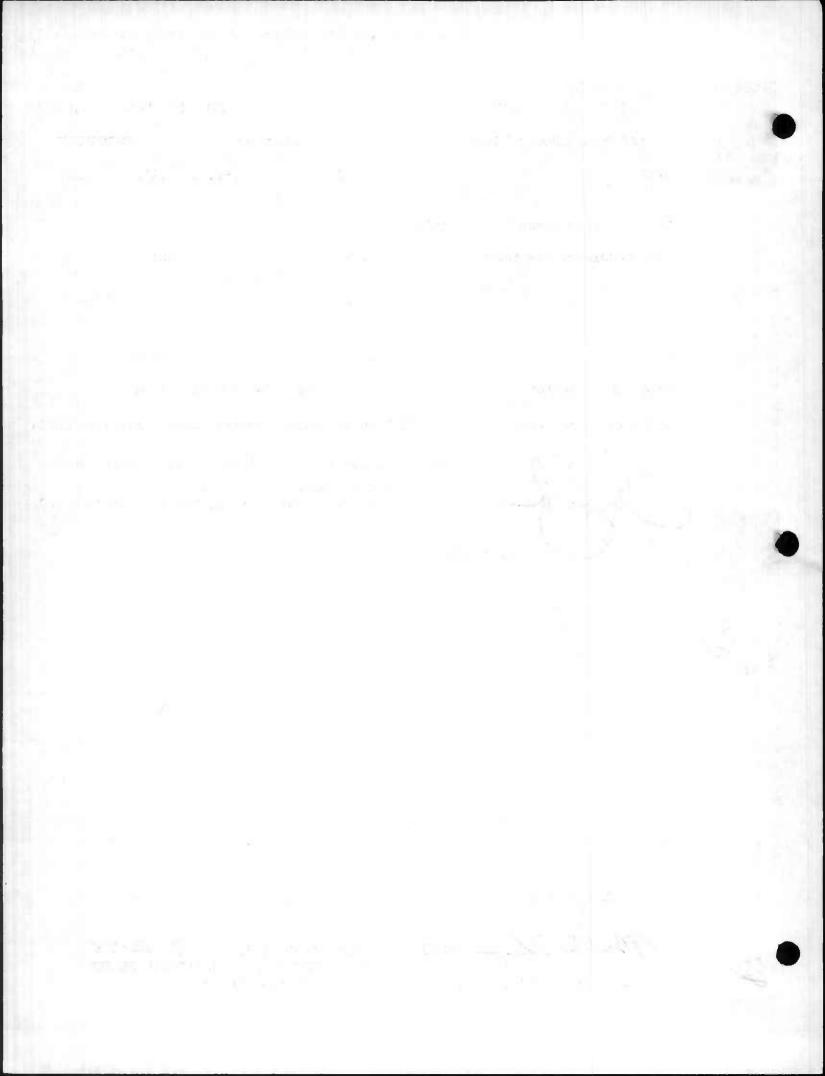
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

						Cert	tificate	e of	Death			Reg. No.			7116
Physicia	_	1. Decedent's Neme (First, Middle,	Last)			5-3					2. Dete of D Month	eeth Dey	Ye		Time of Deeth
Physiciar /Medica	_	JOEL RYA	N KOSI	rek							SEP	19	1998		4:00 AM
Examine		4e. Fecility Neme (If not institution,	give street end i	number)				C	4b. City, To	wn, or Lo	ocation of Dee	th 4c.	County of E	Deeth	
		NATIONAL NA	VAL MEI	DICAL	CENTER				BE	THES	DA		MO	NTGOM	ERY
Funeral		5. Sociel Security Number	Sex 10XM 2□ F		In yrs. lest birt		If Under	1 Year Deys		24 Hrs. Min.	8. Date of B	ley, Year)	9.	Birthplece Country)	(Stete or Foreig
Director		N/A	TODAY ZUF			Yrs.		3			Sept.	16, 1	1998 1	Mary1a	and
*	1	Usuel Residence of Decedent 10e. State 10b. County		1	Oc. City, Town	or Loca	ation							10d le	nside City Limit
Examinet must be notified at	0														☐ Yes 2XIN
289	Director	MD Anne .	Arundel		Laure	L	10f. Zip	Codo				10a Ohla	14 <i>l</i> h		
0 8	2		.11 0										en of Whe	t Country?	
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0	by	1 Never Merried 2 Married 3 Widowed 4 Divorced	If Yes.	s 20 No Give r Detes:		1[☐ Yes 2	No	Specify:				Specify:	White	2
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polical	et	(Specify only highest	grede complete	d)	100.	(Give ki	ind of work	k done	during most	t of work	ing	160. Kii	id of Busini	ess/industry	
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	o Be	Ward Conway Ko	stek								Dawn I				
traumetic	0	19e. Informant's Name/Relationship			19h	Melling	Address	/Street			al Route Numi			to Zin Code	2)
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other	-	20e. Method of Disposition	K/I aleli		20b. Plece of				LSVIII	.e 50	Dete Dete		-	or Town, S	
		1 X Burial 2 ☐ Cremetion 3		m State			atory or ot								
eny injury or		4 Donetion / 5 Other (Spe	cify)		Rosehi						9/25	Mino	ot, No	orth I	Dakota
Duce	1	21. Signature of Funeral Service Lie	1//			F F	leck	Fu	ess of Fecilit neral	y Home	e, Inc.				
		1 ich	1								Road,		1, Ma	arylar	nd 2070
edical aminer	iner	Immediate Ceuse (Fin disease or condition resulting In deeth)	H)		ENCEPHA se to (or es e c		ence of):						-		
out and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	6	Du	e to (or es e c	onseque	ence of):								
	Medic	thet initieted events resulting in deeth) Lest	1 d.	Du	e to (or es e c	onseque	ence of):								
and the	Physician	Pert II. Other significant conditions	contributing to	deeth but r	not resulting in	the und	dertylng ce	use gi	ven in Pert I.		23b. Dtd	l tobacco i	uea contrib	outa to the	cause of deat
	oy Pru										1	Yes 2	No 3[Probably	4 Unkno
2 should b	Completed									_		s en eutop: formed?	sy 24	eveileble	utopsy finding e prior to ion of cause ?
page 2	0										1 📉	Yes 2] No	1 🗆 Yes	2 No
rector, pag		25. Was cese referred to medical							26. Plece	of Deat	h (Check only	one)			
0 0	0	exeminer? 1 ☐ Yes 2 ☒ No	Hospital: 1	□ Inpatient	2 □ ER/Out	tpetient	3 DO/	A Oth	hor		me 5□Res		Other /5	Specify)	
= -		27. Menner of Death 1 ▼Neturel 5 □ Pending 2 □ Accident Investigat	(Mo	te of Injury onth, Dey Y	(ear) 28b. T	ime of njury	M 28	kc. tnju: Wo			28d. Describe				
in by	Certific	3 Sulcide 6 Could no determine	288. PIB	ce of Injury ilding, etc. (- At home, far Specify)	m, stree	et, factory,	office			28f. Location City or To	(Street end own, Stete)	i Number o	r Rural Rou	ite Number,
completely filled in by		29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	aminer: On the	he best of n besis of ex enner stete	camination end	death of	occurred e estigetion,	t the th	me, date en opinion, deel	d plece, th occurr	end due to the red et the time	ceuse(s) , date end	and menne plece, end	r as stated. due to the o	cause(s)
D D		29b. Signeture end title of certifier	-1				29c.	Licens	se number			29d. Date	signed (M	lonth, Dey,	Year)
0		marla	0//		mn		/.	301	060500) (M	T)		-22	- 4	
/		30. Neme end eddress of person wh	o completed ca	use of deet	th (Item 23e) (Type Pr		201			NAVAL				
Z		MARK W. THOMPSO				- ypo, r:					MD 208			or and and a to	
State Registrar		31. Date filed (Month, Dey, Yeer) SEP 2 5 19	198 32.	Régistrar's	Signeture	9.	100	K	2						

Registrar



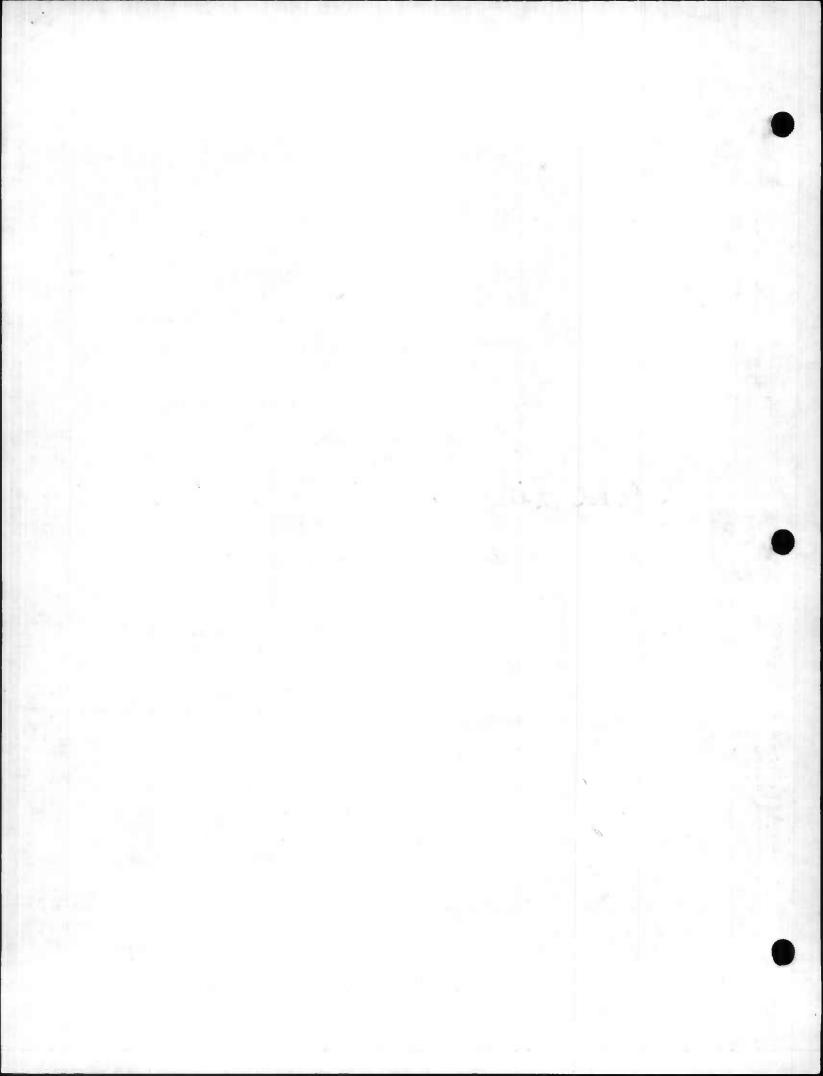
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 19^{Dey} **Physician** SEP JASON ALEXANDER KOSTEK 1:10 AM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex 14 M 2□ F 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year Birthplece (State or Foreign Country) **Funeral** Months Deys Yrs. Director N/A Maryland Usuel Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Mexical Examiner must be notified at 1 ☐ Yes X☐ No Director Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? or items 23a or 3378 Suddlersville South 20724 USA 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. within 72 hours efter 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White by 3 Widowed 4 Divorced Yeer or Dates Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed a ment of Heelth end Mental Hygie mt. If Ilem 27 is marked other Infant Infant 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Ward Conway Kostek Melinda Dawn Llewellyn 19e. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Heelth el Important: If Item 27 is any injury or other trac M/M Ward Kostek/Parents 3378 Suddlersville South, Laurel, Maryland 20724 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 2 Cremetion Removal from State Rosehill Cemetery 9/25 Minot, North Dakota 22. Name end Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 ations that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate 11. Enter Approximete intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (diseese or condition resulting in death) HYDRANENCEPHALY Examiner Due to (or es e consequence of): Physician/Medicai Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury Ihet initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Box P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobscco uss contributs to the cause of death? by the 1 Yss 2 No 3 Probably 4 Unknown signed l Records, by 24b. Were sutopsy findings eveilable prior to completion of cause of desth? page 2 should Completed 24e. Wes en eutopsy performed? peed 1 Yes 2□No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician:
124 hours efter death.
 Funeral Director: After this certifical elethy filled in by the funeral director. Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1☐ Yes 2√2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Localion (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Notes that the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es steted.

2 Madical Examíner: On the basis of examinetion end/or Investigetion, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier Medical To the I within 2 To the I 29d. Dete signed (Month, Dey, Yeer) 29b. Signeture end title of certifies 29c. License number 9-22-98 MO 4301060500 (MI) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) NATIONAL NAVAL MEDICAL CENTER MARK W. THOMPSON, MAJ, MC, USA BETHESDA MD 20889-5600 32 Registrar's Signature State oaks Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Physician 12:55 P.M. Manuel Katsuleres 21 1998 Sept. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1301 Peachwood Lane Prince George's Bowie If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 2, 1947 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 MM 2□ F California 176 36 6582 51 Yrs Director Usual Residence of Decedent with the Maryland 10h County 10c. City, Town or Location ahow 10d. Inside City Limits 1 No Yes 2 No Director Prince George's cmust be notified Maryland Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or items 23s or 1301 Peachwood Lane United States 20716 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic and Welder Amusement Park permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other any injury or other trauments of the page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Nikalay Katsuleres Anina Cash 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Karen Katsuleres 1301 Peachwood Lane Bowie Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State Grandview Cemetery 9/26/98 Monessen Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility
Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in death) carcinon Examiner Due to (or as a consequence of): Examiner physicien end the burlet-transit The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): for use as P.O. 1 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown stope rend disease Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Insulin dependent diabetes page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital after death.

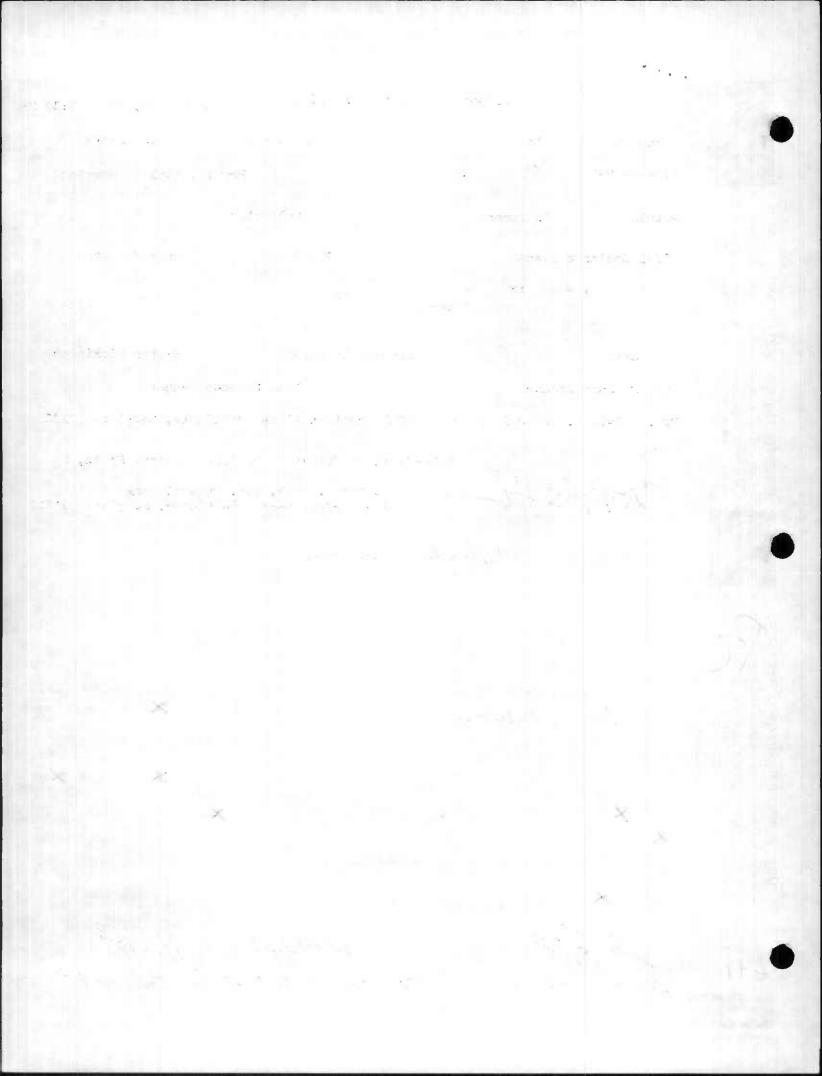
Director: After this certifica director. 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Injury et 28d. Describe how injury occurred 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide filled in 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. To the Hospi within 24 hour To the Funer completely file Medical 29a, Certifier 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35820 MID 30. Name and address of person who completed cause of death (Item 23s) (Type, Print) E-Kborg M. called tox Lave #110 BOWIE, MD 14300 M.D 31. Date filed (Month 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Death Month Dey Yaer September 23, 1998 Kroedel **Physician** Nelson John 9:30 PM /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3501 Moultree Place Fullerton Baltimore If Undar 1 Year If Under 24 Hrs. 5. Social Sacurity Number 7. Aga (In vrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Yaar) **Funeral** Months Deys 15 M 2 F Hours 56 Director 212-42-5527 May 18, 1942 Maryland Usuel Rasidenca of Decedant the Marylend 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Baltimore Fullerton 1 ☐ Yes 2 No Directo 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 3501 Moultree Place 21236 United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. MXYas 2 □ No If Yas, Giva Yaar or Datas: 1964-66 1 ☐ Navar Marriad 2 ☑ Married Maryland 21215-0020 1 ☐ Yas 20XNo Specify: Specify: þ 3 Widowad 4 Divorced White Completed 16a. Dacedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Becton Dickinson Process Operator 12 Years 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Pages 1 and 2 should be fill ment of Health end Mental H Elmer Henry Kroedel Anna Frances January 19a. Informant's Name/Ratationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 3501 Moultree Place Baltimore, Maryland Mrs. Sylvia K. Kroedel Wife Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other pleca) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Crametion 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) MSVC-Garrison Forest 9/28/98 Owings Mills, MD 21. Signature of Funer 22. Nama and Addrass of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, Maryland antartha moda of dying, such as cardiec or raspiratory arrast. 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not antar shock, or haart failura. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final Myocardial disease or condition rasulting in deeth) Examiner Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Diseasa or Injury that initiated avants rasulting in daath) Last Dua to (or as e consaguanca of): Box 68760 Due to (or es e consequence of): **Physician** M Part It. Other significant conditions contributing to deeth but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yss 2 No 3 Probably 4 Unknown 2 signed be det þ 24b. Were autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy Completed 1 Yas 2 No 1 Yes certificate Attending Physician: funeral director 25. Was casa rafarrad to medical Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa Spasidance 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Certification: To this 28a. Date of tnjury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. tnjury at Work? 28d. Dascribe how Injury occurred After 1 ANaturel 2 Accidant 5 Panding or Attending after death. Director: Aft 1 Yas 2 No investigation 6 Could not be datarminad 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 4 | Homicida Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and mennar as stated.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier Medicai (Check only one) To the To the To the I 29b, Signature and Ittle of cepitler. 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) ad North Point RD. Bultimore, MD 21224 Kinzingel MO 31. Data filad (Month, Day Year) SEP 2 5 1998 32. Registrar's Signatura State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#19a per FH G763 9/25/98 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPT. **Physician** ERNEST NIGHT 10:40 A.M /Medical 4c. County of Death 4e Facility Name (If not Institution, give street and number 4b. City, Town, or Location of Death Examiner Ballimore orlev 009 Hours Min. 8. Date of Birth (Month, Day, Year)

March 31 1928 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Deys Months 18 M 2□ F 70 240-32-8531 Yrs NC Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Baltimore 1 Xes 2 No Director 'natural', or lients 23s or 28s-f 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 5009 Rd orlev U.S.A 21207 Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11 Merital Status Bleck, White, etc. 1 X Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 200 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Protective Elementary/Secondery (0-12) College (1-4or 5+) Officer Gout. tederal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Important: If Item 27 is marked of any injury or other Be Pages 1 and 2 should be Bertha Brice To hristopher Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ora Dalle Corley WI. 5009 Rd. Snight -0 Datto, Md. 21207 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from Stete 9/26/98 Wood lawn BA-Ho. Md 4 ☐ Donetion 5 ☐ Other (Specify) 32 Name and Address of Facility James A. Mor 21. Signature of Funerat Service Licensee Sons ton BAlto, Md. ST. 1701 Laurens reo Solow 23a. Perty Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical tmmediate Cause (Finat 9 months Metastatic disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed b Records, à 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24e. Was en autopsy performed? 1 Yes 2 2 No 1 ☐ Yes 28 No Division of Vital f or Attending Physician: after death. Director: After this certifica director. 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Dete of tnjury (Month, Dev Year) 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral D 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29e. Certifier To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

31. Date filed (Month, Day, Year) State Registrar

SEP 2 5 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

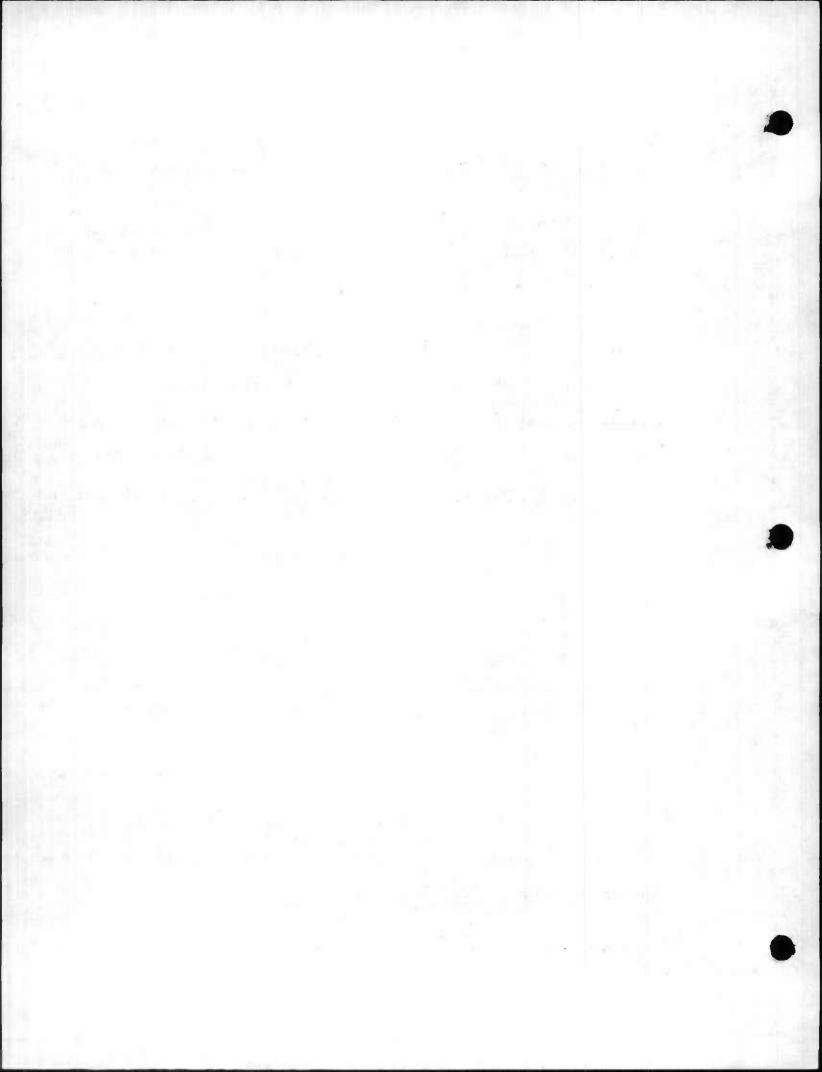


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Abenaa Brewster Johns Hopkins Hospital

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September, 24, 1998



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State Registrar

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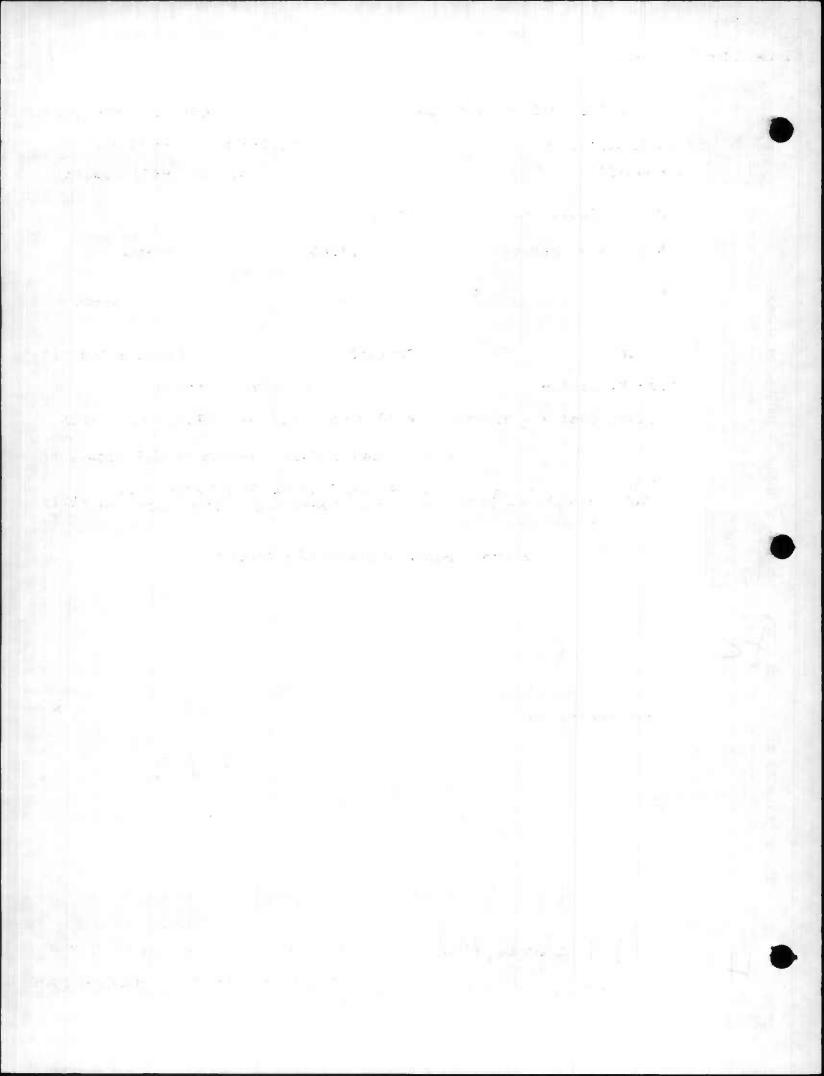
111 Penn Street, Baltimore, Maryland 21201

of death (Itam 23a) (Type, Print)

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O.C.M.E.

September 23, 1998



WRC .-98-5508-003 Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. **JEFFERSON** State of Maryland / Department of Health and Mental Hygiene MILLER Amend: #10c Per FH Film G763 9-25-98RC Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Data of Death Dey Month Year **Physician** Jefferson Miller SEPTEMBER 19, 1998 9:30 AM. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS Anne Arundel Birthplaca (Stata or Foraign Country) If Undar 1 Yeer if Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 6. Sex **Funeral** 10XM 20 F Months Days Hours Yrs. South Carolina 04/15/1953 Director 45 212-58-3233 Usual Rasidanca of Decedant the Maryland 10d. insida City Limits r 28a-f show 10c. City, Town or Location 10e. Stete 10b. County WOODLAWN 1 ☐ Yes 2 No Directo Baltimore Maryland | Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with "natural", or items 23s or edical Examiner must be pemit. Pages 1 end 2 should be filed within 72 hours after death 1 Department of Health and Mental Hydjene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examines must page. 21244 U.S.A. 3404 Washington Avenue Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No if Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian. Bleck, Whita, atc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Wirlowed 4 ☐ Divorcad Completed 15. Decadent's Education (Specify only highast grada complated) 16a. Decadant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamentery/Secondary (0-12) Collaga (1-4or 5+) 12 Chef Hospital 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Neme (First, Middla, Lest) Willie Mae Miller Albertis Gibson 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 3404 Washington Ave., Baltimore, Maryland 21244

20b. Place of Disposition (Name of Camatary, crametory or other place)

Data

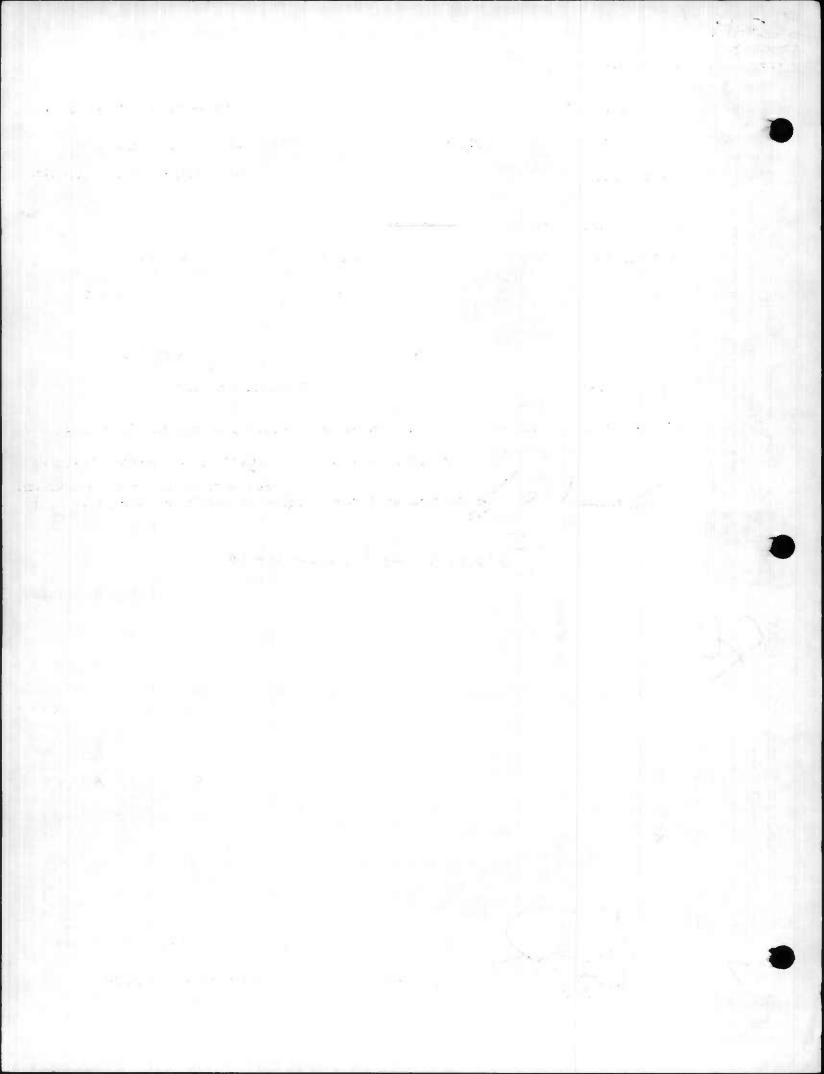
20c. Location - City or Town, State Willie Mae Lowery/Mother 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramovel from Stata 09/26/98Landsdowne, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Mt. Zion Cemetery 22. Nama and Addrass of Facility
The Derrick C. Jones Funeral Hm. 21. Signatura of Funeral Sarviçe Licansaa 4611 Park Heights Ave., Baltimore, Maryland 21215 23e. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Daath **Physician** /Medical Immediate Causa (Final disaasa or condition resulting in daath) Examiner Examine Sequentially llst conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disease or injury thet initiated avents rasulting in daath) Last Dua to (or as a consequence of) Brid edical Dua to (or es e consequenca of) Physician/M Division of Vital Records, P.O. Box The law requires that the death for 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings evailable prior to completion of causa of deeth? been sign 24a. Was an autopsy Completed s certificata has b director, paga 2 s 1 Yes 2 □ No 1 Yas 2 No or Attending Physician: director, Be 25. Was casa rafarrad to medical axaminar? 26. Plece of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1⊠ Yas 2□ No 1 inpatiant 2 XER/Outpatient 3 DOA Certification: To this After this 28c. Injury at Work? 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No death. Invastigation 2 Accidant Director: A 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide the Funerei Di the Funerei Di npletaly filled in Hospital 1D Certifying Physicien: To the bast of my knowledge, death occurred at the time, data and place, end due to the causa(s) and menner as stated.

2X Medical Examinar: On the basts of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the edical 29a. Cartifier iner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. (Check only one) within 2 To the 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signature as SEPTEMBER 20, 1998 O.C.M.E. 30. Name and a pplated causa of daeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

32. Ragistrar's Signeture

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Mor



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State of Maryla	nd / Department of Health and	Mental Hygiene	00: 70
ilm G763 9-25-98RC	Certificate of Death	Reg. No.	29479
Middle, Last)		2. Date of Death	3. Time of Death
INTA McCANDLESS		SEPTEMBER 19,	1998 4:50 PM.

Physician /Medical Examiner

Funeral Director

the Maryland

7 is marked other than "natural", or items 23s or 28s-f show trsumstic event, the Modical Examiner must be notified at Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If Item 27 is marked other than "natural", or ite other 1 permit. Page Department o Important: If any Injury or 6

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

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Division of Vital Records, P.O.

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McCANDLESS Amend: #19a Per FH F 1. Decedent's Name (First, I SEPTEMBER 19, 1998 DORA VIRGINIA McCANDLESS 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death BRANCH AVE AND MALCOLM RD. CLINTON Prince George Co. If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) 1□ M 21 F Months Days Yrs. 412-76-2639 October 17, 1920 Tenn Usual Residence of Decedent 10d. inside City Limits 10a State 10h County 10c. City. Town or Location Director MAryland | Prince George Co. Andrews AFB 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4771 Cleveland Lane 20762 U.S.A.

14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) Greeter 12 Walmart 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Taylor Houston Lottie Lois Vann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informent's Neme/Relationship (Type, Print)
Mac Petrowski Mae Houston (Grandson) 4771 Cleveland Lane, Andrews AFB MD 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 9/24/98 Collierville. Magnolia Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility 4107 Wilkens Avenue HUBBARD FUNERAL HOME Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, or heart fellure. List only one cause on each line. Immediate Cause (Final disease or condition resulting In death) Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 Nunknown à 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was an eutopsy Completed 1 Yes 2□ No 1 Yes 2□ No 88 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 X Yes 2 No 27. Manner of Death 5 Pending investigation 1 Naturel 2 Accident

3 ☐ Suicide

29a, Certifier

31. Date filed /Mo

4 Homicide

6 Could not be determined

Dete of Injury (Month, Dev Year) 9.19.98

4.37 8

28b. Time of 28c. Injury et Work? 1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred Disprin auto/a Cellision 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and (itle of certific

O.C.M.E.

29c. License number

29d. Date signed (Month, Day, Year) SEPTEMBER 20, 1998

1 ☐ Yes 2 ☐ No

21229

Approximete intervei Between Onset and Death

AT

SCENE

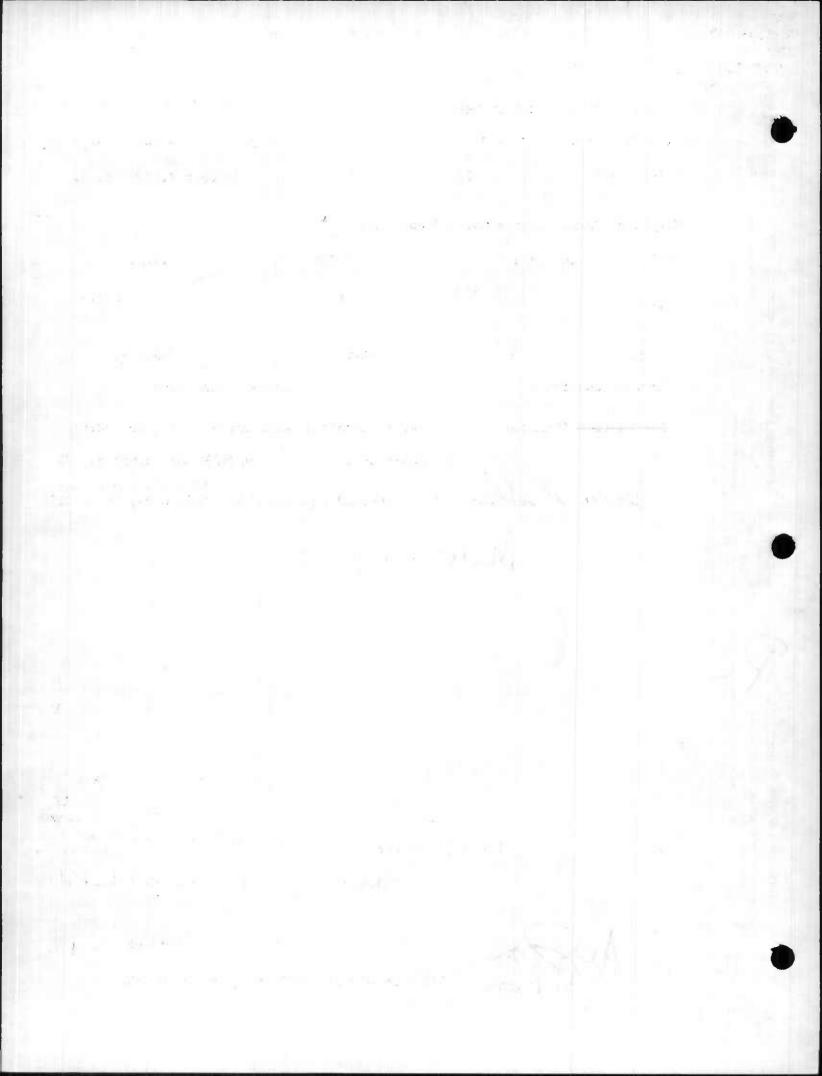
o completed cause of deeth (item 23a) (Type, Print) 30. Name and add

111 Penn Street, Baltimore, Maryland 21201

State Registrar

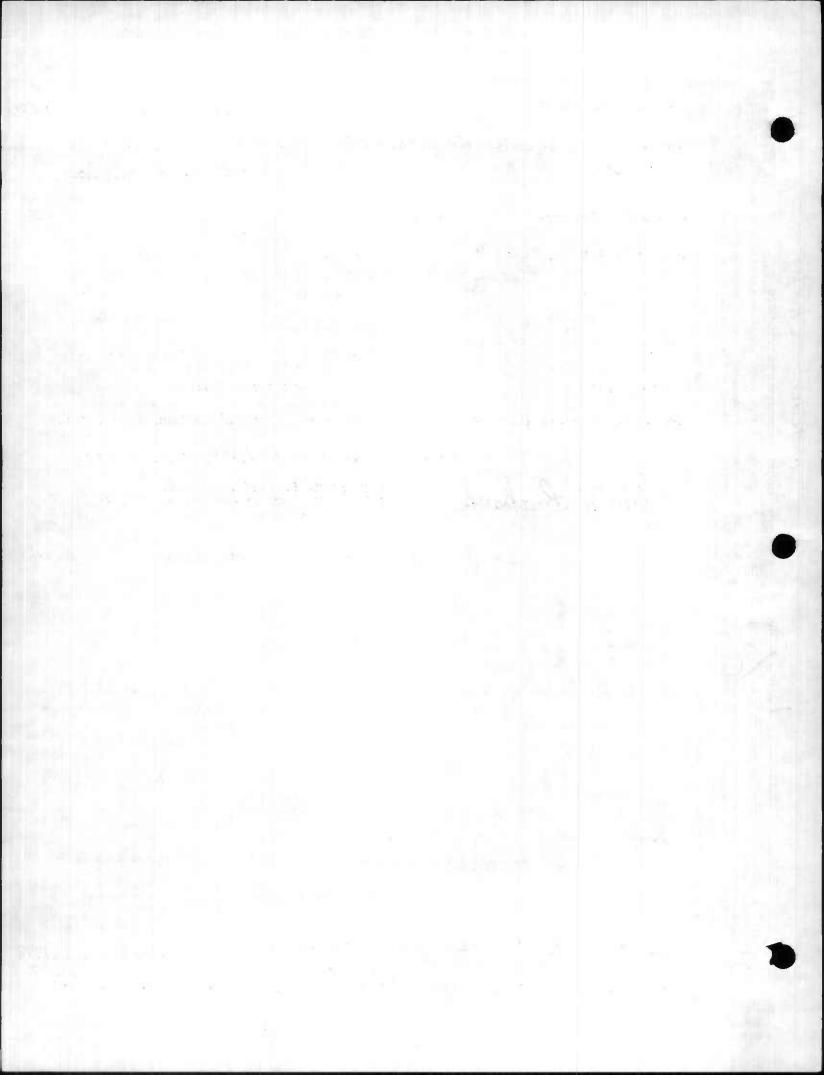
edical

3. Registrar's Signature



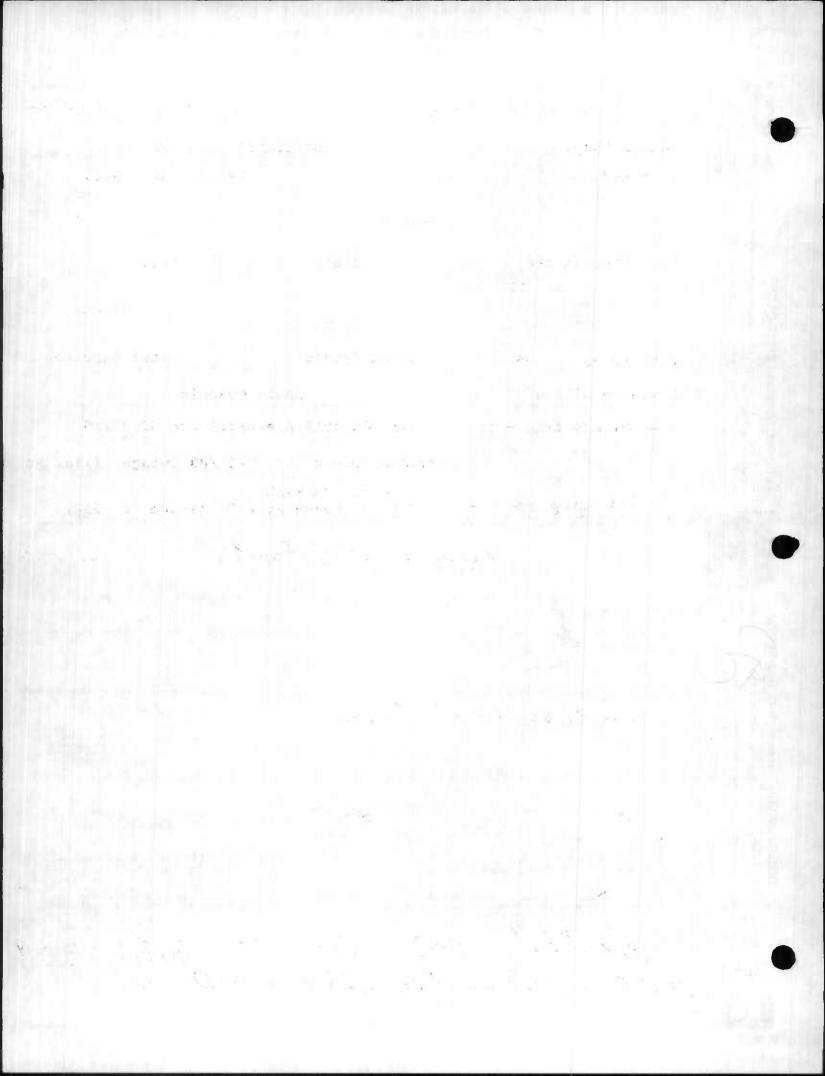
State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Neme (First, Middle, Las)					2. Date of Dea		3. Time of
Shirley Ann Matzdo	rf					Septer	Day	Year 2,1998 3:20
edical 4a Facility Name (If not institution, give	street end number)			4b. City, T	Town, or Loc	ation of Deeth		
() . l. (H.	ospital	Cente	er Po	red	/e	Ro	Himore
5. Social Security Number 6. Se		yrs. lest birthdey)	It Under 1	Yeer If Unde	er 24 Hrs.		th	9. Birthplace (State of Country)
219 52 8463	□M 280 F 49	Yrs.	Months I	Days Hours	Min.	B. Dete of Bird (Month, De Aug. 20	1949	Maryland
10a. Stete 10b. County	100	City, Town or Lo	ocation					10d. Inside Cit
Maryland Baltimore	06191-19	Essex						1 ☐ Yes
Maryland Baltimore 10e. Street end Number			10f. Zip C	ode			10g. Citizen of V	What Country?
	"Apt A2"		212	221			USA	
11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates;		Was Deceder If Yes, specify 1☐ Yes 25	nt of Hispanic O y Cuban, Mexico X No Specifi		ify Yes or No ican, etc.)	14. Rac Blac Specify	ce - American Indien, ck, White, etc. y: White
15. Decedent's Edi (Specify only highest grad	icetion	16e. Deced	dent's Usual (Occupation	ast of workin	0	16b. Kind of Bu	usiness/Industry
15. Decedent's Ed (Specify only highest grad Elementary/Secondery (0-12) 12	College (1-4or 5+)			done during mo retired)	Dat Of WOTAN			
12			Waitre				Restau	
17. Father's Name (First, Middle, Last)				18. Moti	her's Name	(First, Middle,	Meiden Sumen	ne)
Stanley Holcomb	the state of the state of			Ger	caldin	e Shif	flet	
19a. Informent's Neme/Relationship (T			-					Stete, Zip Code)
Dennis G. Matzdorf					"Apt	A2" Ba	Itimore	, Md. 21221
20a. Method of Disposition 1 Burial 2 Cremation 3 DI	Removal from State	Ob. Place of Dispo cemetery, crer	metory or other	er place)	- 1	Date		City or Town, Stete
4 Donation 5 Other (Specify		Greenmour	nt Cre	matory	9/24/	1998	Baltimo	ore, Md.
21. Signatura of Funeral Service Licens	00 0	22 B	2. Name end .	Address of Faci	ility ineral	Home	P.A.	
Workin W. K.	un fourte.						ssex, M	d. 21221
23a. P.m. Enter the disease, or comp								
Immediate Cause (Final disease or condition	lications that caused the ne ceuse on each line.	death. Do not ent	ter the mode	of dying, such a	as cerdiac or			Approximate Interval Betwood Conset and D
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State of Maryland / Department of Health and Mental Hygiene 9 8 29481

	Certificate of Deal	th	Reg. No.	60401
	1. Decedent's Name (First, Middle, Last)	2. Dete of	Death	3. Time of Death
Physician	Richard MCOVSFie	Seol S	molen 22	1958 0902
/Medical Examiner		, Town, or Location of De		
Examiner				
Comment	Sinai Hosp. 5. Sociel Security Number 6. Sax 7. Aga (In yrs. lest birthday) If Undar 1 Yaar If Un	timore	Birth	9. Birthplace (State or Foraign
Funeral Director	1 1 M 2 □ F		Dey, Year)	Country)
	216-24-9534 68 Tis. Usual Residence of Decedent	04	29 30	N.C.
land land	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
the Marylar 28a-f show cuttled at	MD NA Baltimore			17 Yas 2 □ No
the the	10e. Street and Number 10f. Zip Code		10g. Citizen of Wi	net Country?
officer death with the Maryland reference 23a or 28a-1 show giver must be notified at Funeral Director				
me 23a	5439 Jonquil Ave 21215	Origina (Consider Vac or	U.S.A	- Amarican Indian,
Hems Rems	11. Merital Status 12. Was Decadant Ever in U.S. Amed Forces? 13. Was Decadent of Hispanic If Yes, specify Cuban, Mex	dican, Puarto Rican, etc.)	Black	, Whita, etc.
Urs after	1 □ Never Married 2 Married	oify:	Specify:	
21215-0020 d within 72 hours after plane. r than "natural", or lite to Medical East rife.	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Black
1 21215-0 ed within 72 ho ygiene. ner than "nature it, tre Medice. Completed	15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during in	most of working	16b. Kind of Bus	iness/industry
within within the men.	Elamentery/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)			
Co Spier	12th grade NA Truck Driver 17. Father's Name (First, Middla, Last) 18. Mc			Service
Be Be	17. Father's Name (First, Middla, Last)	lother's Name (First, Mide	ne, meiden Sumeme)
should be a should be a marked of umatic eve	Lawrence Willis A	nnie Crado	die	
iore, Maryland 212 ges 1 and 2 should be filed withi t of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, trau To Be Comp	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Nu			Stete, Zip Code)
other train	Erma M. McDuffie -wife 5439 Jonquil	Ave, Baltin	nore Md	21215
Baltimore, semit. Pages 1 are separtment of Hear moortant: If Item 3 my injury or other and I.	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery cremetery cremetery cremetery cremetery cremetery cremeters)	Date		City or Town, Stata
	1 \(\mathbb{K}\)Buriel 2 \(\text{Cremation} \) 3 \(\text{Ramoval from State} \) 4 \(\text{Donetion} \) 5 \(\text{Other} \) (Specify) \(\text{Garrison Forest V} \)	at 19/28/0	as Owing	a Milla Ma
Baltin permit. Pa Departmer important: any injury once.	21. Signature of Funerel Servica Licensee 22. Name and Address of Fa		ob Owing.	5 MILIST MU
Ba Depa impo any is	March F/H W	oet		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heert failure. List only one cause on each line.	Ave, Bal	imore M	d 21215
STATE OF THE PARTY.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heert failure. List only one cause on each line.	as cerdiac or respiretor	y errest,	Approximate Interval Between
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8	resulting in deeth) Lest			
X (5	d			
m 1	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in P	Oct 1 29h F	ld tobecco use con	tribute to the cause of death?
P.O. at the di by the etached				
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cords, P.O. vequires that the di been signed by the should be detached		040.14	(as as autora]	24b. Were autopsy findings
Or requ		240. 40	las an autopsy arlormed?	available prior to completion of cause
Rec elaw has b ge 2 st				of death?
The la ate ha page		1	☐Yes 2 No	1 ☐ Yes 2 ☐ No
Vital F sician: The cartificate irector, pag	25. Was casa referred to medical 26. P	Place of Death (Check on	nly one)	
of Vita Physician: this cartific ral director,	examiner? Hospital: Other	□ Nursing Home 5 □ R		r (Specify)
0 E E =	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury et		be how injury occurre	
Vision Attending For death. by the funar	1 Maturel 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident Investigation M 1 ☐ Yes 2	2 No		
Attendictor: A the f	3 Suicide 6 Could not be 28e, Plece of Injury - At home, farm, street, factory, office			or or Rurel Routa Number,
Div.	4 ☐ Homicide building, etc. (Specify)	City or	Town, Stete)	
ours ours fille fille C	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date	te and place, and due to	the cause(s) and mai	oner as stated
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	(Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	death occurred at the tim	ne, dete and place, a	nd due to the ceuse(s)
Mec	29b. Signatura and titla of cartiful 29c. License numb	ber	29d Date signed	(Month, Dey, Year)
8 1 1 1	NULL MAD DO	977	(X	1 10-0
10.4	Mount x 1/11)	100	Jag/en	Sen 23 1798
4+1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	40 Y	7	
	2433 West Selvedere / Ve Bellim	one IVII.	1212/2	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			1 1 1
Registrar	SEP 60 1990			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 1998 Alexander Moblev Sep tember 21:45 22 4a Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Sacurity Number If Undar 1 Yaar 8. Date of Birth Month, Day, Year) 09-16-54 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months Deys Hours Min 18 M 2□ F MD 44 Yrs. 218-60-4333 Usual Rasidance of Dacedant 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits Md X Yes 2 No NA Baltimore 10e. Streef and Number 10f. Zip Coda 10g. Citizan of What Country? 325 East 22nd. Street 21218 USA 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas ¾ 3√No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Marital Status Black, Whita, atc. 1 Never Marriad 2 Married 1 ☐ Yas 🛠 ➡ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Laborer 10th grade Unemployed 18. Mothar's Nama (First, Middla, Meidan Surnama) 17. Fathar's Nema (First, Middla, Last) Mannie Mobley Marie Brown 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stete, Zip Code) 21218 19e. Informent's Name/Reletionship (Type, Print) Viola Mobley 325 E. 25th Street Baltimore, Maryland 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata X Burial 2 □ Cremation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Voshell Mem. Gardens 09-29+98 Dundalk, Md. 21. Signature of Funaral Sarvice Licansa 22. Nama and Addrass of Facility Baltimore, Maryland21202 WM.C.March FH 1101 E. North Avenue 23a. Partf. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such es cardiac or respiretory errast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Daeth Immediate Ceuse (Final disease or condition rasulting In daath) 4 days Dua to (or as a consequence of): Alcoholism Unkhown Dua to (or as a consequance of): Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Disaasa or Injury disease V Houn Stack liver that initiated avents rasulting in daath) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings eveilabla prior to 24a. Was an autopsy complation of ceusa of deeth? 1 Yes 2 No 1 Yas 2 No 25. Wes cese referred to medical axaminar? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manpar of Deeth 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) 1 (Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be detarmined 3 Sulcida 28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicide

Physician /Medical Examiner Mobile Flexande

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death a tent of Health and Mental Hygiene.
Int: If Hear 27 is marked other than "natural; or items 23 min; If the or other traumatic svent, the Medical Exaction many or other traumatic svent, the Medical Exaction man.

parmit. Page Department of Important: If any injury or once.

Director

Funeral

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Completed

Be

Physician/Medical Examiner

by

Completed

Be

P

Certification:

Medical

the Maryland

State

31. Data filed (Month, Day, Yaar) Registrar

29a. Certifier (Check only one)

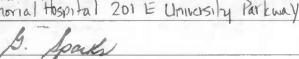
29b. Signature and title of cedifier

30. Name end eddress of person who complated cause of deeth (Itam 23a) (Type, Print) Laura Herra MD

SEP 2 5 1998

MI

Union Memorial Hospital 32. Registrer's Signature



Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and dua to the causa(s) and mannar as steled.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the fime, data and place, and dua to the cause(s) and mannar stated.

29c. Licanse numbar

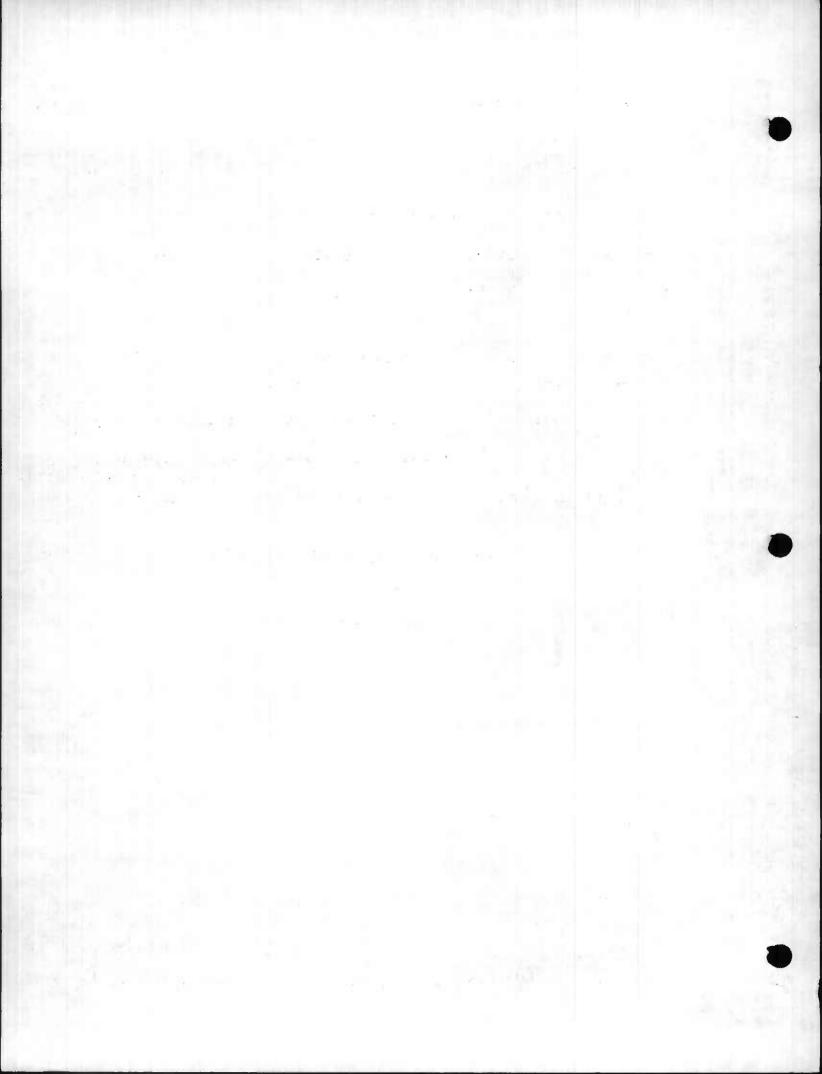
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29d. Data signad (Month, Day, Year)

tember 22, 1998

Kalhmare MD

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items: 26 per MEO G-763 9/25/98 reb Certificate of Death Reg. No. 3. Time of Deeth 1. Decedant's Neme (First, Middla, Last) 2. Data of Death Month Day Physician Sept. 16, 1998 12:28 PM McDaniel Darlene Ann /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Baltimore County Hawthorne 2160 Coralthorn Road If Undar 1 Year | If Under 24 Hrs. Birthplece (Stete or Foraign Country) 7. Aga (In yrs. last birthdey) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 M 2 F Months Hours 39 Yrs. Director 219 78 7355 Oct. 21,1958 Maryland Usual Rasidance of Decedant with the Maryland 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yas 2 □ No Directo Baltimore County Hawthorne Maryland 10f. Zip Coda 10g. Citizan of Whet Country? an "natural", or items 23a or Medical Exercises must be permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Example Trues 1 and DRE. U.S.A. 21220 Funeral 2160 Coralthorn Road 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Bleck, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 X No If Yes, Giva Yaar or Datas: 1 ☐ Yas 2 ☑ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade complated) Elementery/Secondary (0-12) Collaga (1-4or 5+) In Own Home Homemaker 8th 18. Mothar's Nema (First, Middle, Maldan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Lo Rosalie Basford James McDaniel. Sr 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Intorment's Name/Raletionship (Type, Print) James McDaniel, Sr. (Father) 3338 Keswick Road, Baltimore, Maryland 21211

20a. Mathod of Disposition

20b. Place of Disposition (Nama of cematary, crematory or other place)

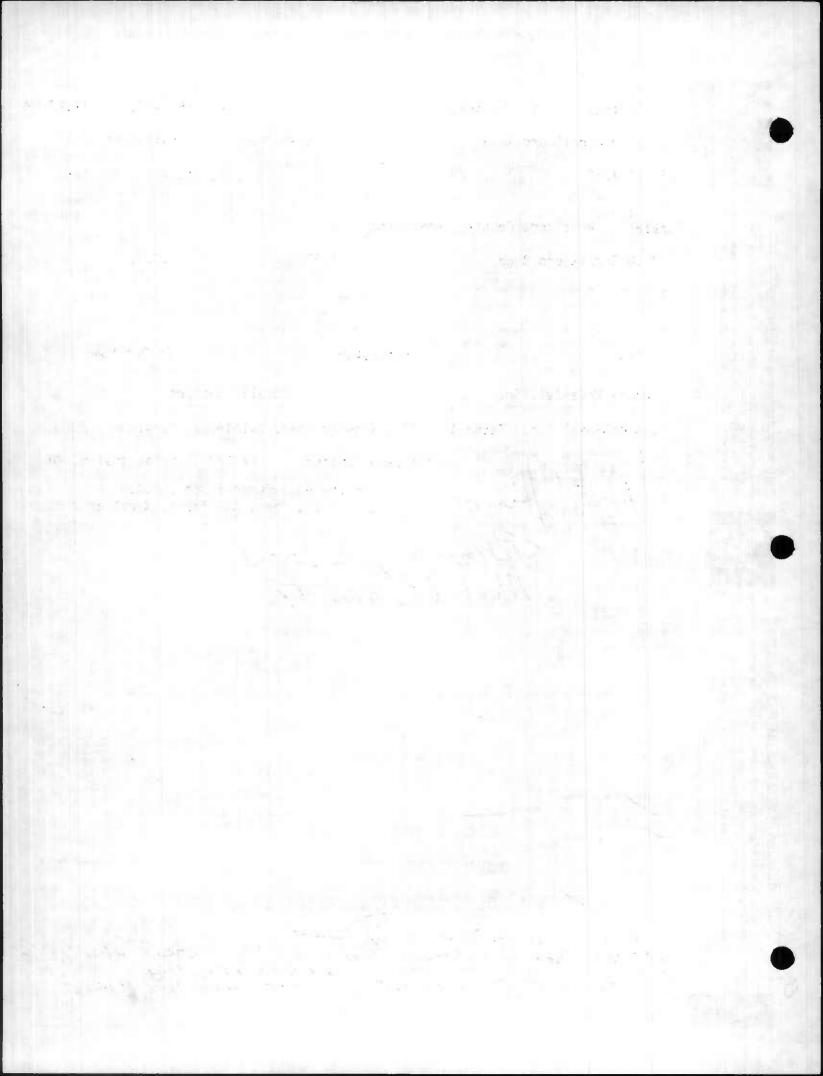
20c. Location - City or Town, State 1 Bu al 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 9/21/98 Marriottsville, MD Crest Lawn Cemetery 22. Nama and Addrass of Fecility 21. Signature of Fuheral Service Ucens Burgee-Henss Funeral Home, P.A. 3631 Falls Road, Baltimore, Maryland 21211 23a. Pertl. Enter the disees shoot, or haart tailura. e, or commodations that causad tha daath. Do not antar List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** Immediate Ceuse (Final disaasa or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated avants rasulting in daeth) Lest and physician a the burtal Box 68760 Physician/Medical Due to (or es e consequence of): # 8 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ě þ 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes en autopsy Completed page 2 1 Yas 2ENO 1 □ Vas 2 □ No 918 25. Was casa referred to medical Be 26. Placa of Death (Check only ona) axaminer Othar: 4 ☐ Nursing Home X ☐ Rasidance 6 ☐ Othar (Specify) 2 No 2 ER/Outpatient 3 DOA Certification: To 200 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Panding Invastigation Attending 1 Natural 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28t. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, tactory, office building, atc. (Specify) 4 Homicida 6 1 Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and manner stated. 29a. Cartifian edical (Check only one) 29b. Signature and title of certifier 29ch License number 29d. Deta signad (Month, Dey, Year)

of person who completed cause ot deeth (Item 23e) (Type, Print)

32. Registrar's Signifi

State Registrar



Please Type or Print in Black Indelible Ink.	Assure All Coples Are Legible.
State of Maryland / Department of H	ealth and Mental Hygiene 98

		State of Maryla		nent of F cate of			giene 9 Reg. No.	8 2	9484
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Funeral Director		M 2□ F 22		nths Days	Hours Mi		y, Year)	Hawa	ece (Stete or Foreign ry) L1
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S viet a			10	f. Zip Code			10g. Citizen of		
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aryla aryla sand Menid I	Charles J. Meyers					N. Pratt			
Aar Mand I sh ma	19e. Informant'a Name/Relationship (Ty	pe, Print) Father				_{Bural Route Numb} Baltimore			
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	Part II. Other eignificant conditions con	tributing to death but not re	esulting in the underly	ing cause gr	ven in Part i.		Yee 2X No		the cause of death'
						24a. Was	an autopsy ormed?	cor	re eutopsy findings illeble prior to npletion of cause leath?
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Ilta Ilan:	25. Wes case referred to medical examiner?				26. Plece of D	eeth (Check only	one)	1	•
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A 4546	(Check only 2 Medical Examination one)	sician: To the best of my kinar: On the basis of examinand manner stated.	nowledge, death occinetion and/or investig	ation, in my	opinion, death oc	ce, and due to the curred at the time,	date and placa,	and due to	the cause(s)
To To o	29b. Signature and title of cartifier	la . Quan	1. Weny		353758		Scipl	, 21	1998
10	30. Neme end address of person who co		7620 YOF		מון דרווים	ON MORY	I OND S	1204	
State	JANE JIA-CHIAN 31. Date filed (Month, Day, Year)	32. Registrar's Sig		IN RUI	TOWS	PIPIN I	horstan/ le	T	

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month September 23, 1998 Arnold William Martin 9:28 PM 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Deeth 302 Hilltop Lane, Apt. A Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) NOV 15, 1912 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Days ₩ 20 F 213-10-4894 85 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits Anne Arundel Annapolis 1 Yes ZONo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Hilltop Land, Apt. A 21403 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck White etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced USA 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Auto Body Shop 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Edward Martin Viola Avers 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 302 Hilltop Ln., Apt. A Annapolis, MD 21403 Ida L. Martin / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 9/24/98 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Humeral Service Libertuse 22. Name and Address of Facility Cremation Society of Maryland, Inc. Gregorchik 299 Frederick Rd. Baltimore, A. MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final of month disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 405TOTIC Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? tis melitan 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? completion of cause of death? 1 Yes 2 The 1 Yes 2 Ye 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

naust be notified at

Hems :

natural, or

permit. Pages 1 and 2 should be filed within 72.
Department of health and Mental Hyglene.
Important: if Item 27 is marked other than "nat, any injury or other traumatic event, the Mattaland.

72 hours after

21215-0020

Baltimore, Maryland

Box

P.O.

Records,

Director

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Completed

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PhysiciaryMedical à Completed

Be edical Certification: To this

Division of Vital he Hospital or Attending Pin 24 hours after death.

The Funeral Director: After the pletchy filled in by the funeral

within 2 To the F

State Registrar

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one)

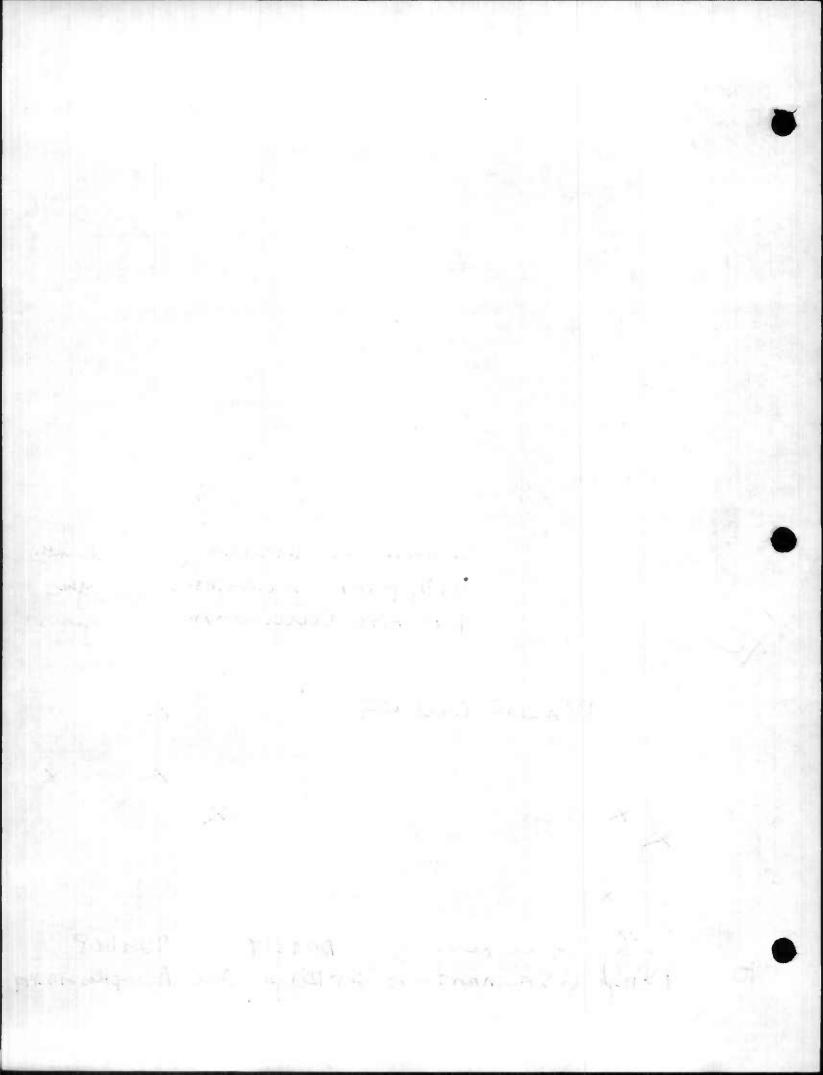
29c. License number

29d. Date signed (Month, Day, Year)

DO8314

205 Ridgely Ave Annopolis mostly

me and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrer's Signeture



	State of Maryland		ificate o			Reg. No.	6	9486
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Wayne	Manning				Month	Dey er 21, 190	Yeer	7: 20 am
4e. Fecility Neme (If not institution, give :	street end number)			4b. City, Town, or	Septemb r Location of Deeth			1.20 9//
Johns Hopkins Bay	view Medical (Centre		Boltimor	e			N/A
5. Sociel Security Number 6. Sex		est birthday)	If Under 1 Yes	ar if Under 24 Hr	s. 8. Dete of Bir	th	9. Birthple	ece (State or Foreig
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Usual Residence of Decedent					1000. /	17340	Ma.	rytand
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Maryland B	altimore			Dundalk				1 ☐ Yes 2 ☐ No
10e. Street and Number			10f. Zip Code			10g. Citizen of \	Whet Count	ry?
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Edward Manning					inia Kran		.3)	
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ras. Reno b. ran				r Road I	oundalk,	Marylan	d 21	222
20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Re	0.00	eca of Dispositi metery, cremet	ion (Neme of tory or other p	lece)	Date	20c. Location -	City or Tow	vn, Stete
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Registrar

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31. Date filed (Month, Dey, Year) SEP 2 5

32. Registrar's Signature

Physicia /Medic Examin

Funeral Director

permit. Peges 1 and 2 should be filled within 72 hours efter death with the Meryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examiner must be notified at once.

Physician /Medical Examiner

an and

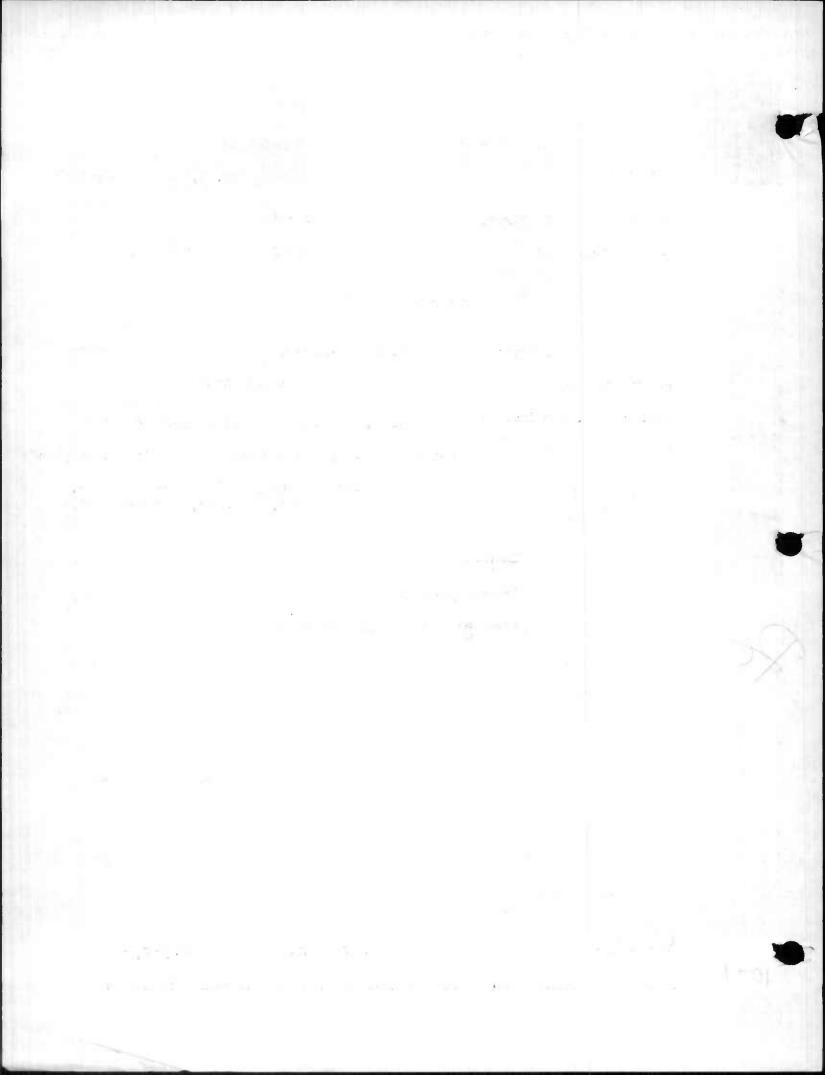
Division of Vital Records, P.O. Box

To the Hospital or Attanding Physician: The law requires that the deap within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attacompletely filled in by the funeral director, page 2 should be detected for

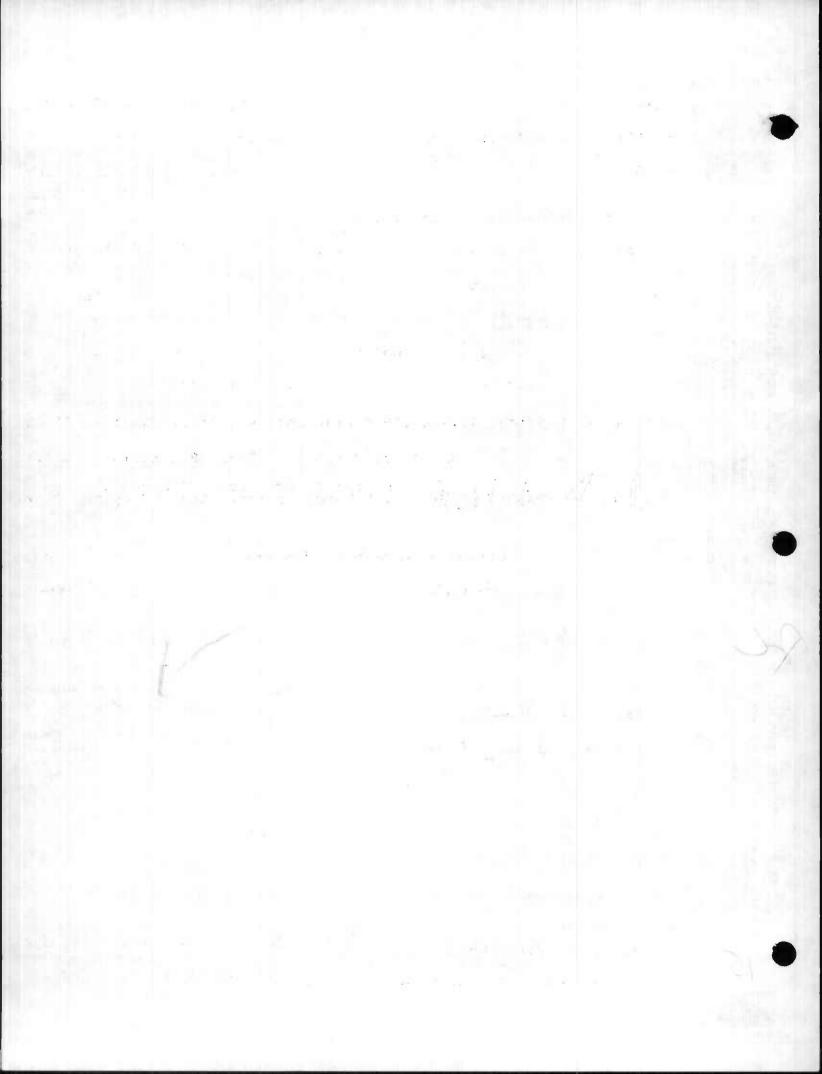
Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Let Allene J. Mud. 4a Facility Name (If not Institution, give St. Elizabeth's 5. Social Security Number 258-07-5760	rich a street and number) s Nursin				4b. City, Town, or L	2. Data of Daa Month Septem ocation of Death	ber 22,	3. Tima of Death 1998 6:35 Death		
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Director	Social Security Number 6. S			3	1	Baltimo	-	N/	Ά		
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ate has been signed by the attending page 2 should be detached for use Completed by Physician/A							101	es 2 No	1□ Yes 21 No		
certificate rector, pa	25. Was case referred to medical					26. Place of Dea	th (Check only o	ne)			
S 0	examiner? 1 Yes 2 No 27. Menner of Death 1 Alatural 5 Pending	Hospital: 1 Inpatie	rry 28b.	outpatient 3 l	28c. Inju			lence 6 Othar			
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within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		1 Willi Muselly D30182 SEPTEMBE									
To the Fund completely I		1	-		03.	0132		SEPTEMBI	ER 23, 199		



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yaar MARTH MOORI 0115 SEPTEMBER 19 1998 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death MEDICAL CENTER BALTIMORE If Undar 24 Hrs. 8. Dat If Under 1 Year 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthdey) Birthplace (State or Foreign Country) 1 M 2 L Months Days Hours 77 Yrs. 218-07-6040 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore N/A 1 ☐ Yes 2 ☐ No 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 21224 U.S.A. 3629 Roberts Place 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Biack, White te 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 □ Widowed 4 □ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hilton Hotel Banquet Waitress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middla, Last) Augusta Stolinski Hermann Splitgerber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3629 Roberts Place Baltimore, Maryland 21224 19a. Informant's Name/Relationship (Type, Print) Charles J. Moore Jr. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other placa) 1 XBuriai 2 Cramation 3 Ramoval from State 9/22/98 Baltimore, Parkwood Cemetery Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John C. Miller Inc. Maryland 21206 6415 Belair Road Baltimore, ons that caused the daath. Do not anter tha mode of dying, such as cardiac or raspiratory arrest, tritervat Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) PANCRGATIC CANCER year Due to (or as a consequence of): Due to (or as a consequenca of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

Physici

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Certification:

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permit. Pages 1 and 2 st Department of Health and important: If item 27 Is in any injury or other traun once.

Physician

' /Medical

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Funeral

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7 is marked other than "naturel", or items 23s or 28a-f show traumstic event, the Medical Experient must be notified at

2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "naturel", or ite

Maryland 21215-0020

Baltimore,

Division of Vital Records, P.O.

certifica

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after deat Director:

To the Hospital within 24 hours at To the Funeral D

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the Maryland

death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

1 Yes

1 Yes 2 No

26. Placa of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Streat end Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred at the fime, data and place, and due to the cause(s) and manner as stated.

[Additional Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 25 No

27. Manner of Death

1 Natural 2 Accident

3 Suicida

29a. Certifier

4 - Homicide

(Check only

29c. License number

28c. Injury at Work?

29d. Data signad (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BMack Candrum MD-

Hospital:

MARK LANDRUM MD 301 ST PAUL PLACE BACTIMORE MD 21202 BENJAMIN

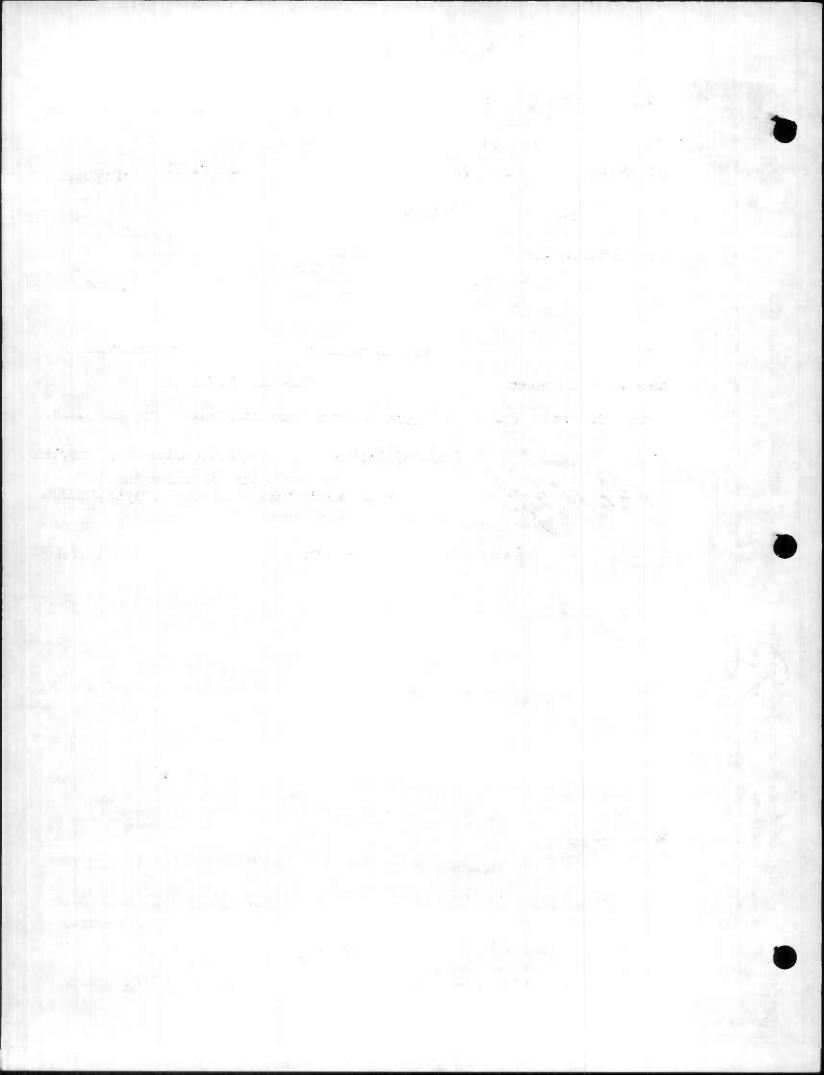
State Registrar 32. Registrar's Signature

npatient 2 ER/Outpatient 3 DOA

28e. Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28b. Time of

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death Day Month **Physician** SEPTEMBER 20 1998 12:15 PM LRENE /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OF MARYLAND HOSPITAL KALTIMORE UNIVERSITY 8. Data of Birth (Month, Day, Year)
Jan. 18, 1935 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (Stata or Foreign **Funeral** Days Hours Country) Maryland 1□M 2ØF Months 63 Director 219-30-2939 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Heelth and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified as 1 ☐ Yas 2 No Director Maryland Baltimore Catonsville 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 118 Glenrae Drive 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, etc. 1 Yas 2X No If Yes, Give Year or Datas: 1K Never Married 2 Married white Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify PV 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administration University of Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles C. Orf, Jr. Irene Henry Tarr

Physician /Medical Examine

pue certificate

this funaral or Attending Pi effer death. | Director: After ti Certification:

Box (Division of Vital Records, P.O.

Registrar

odical

To the Hospital o within 24 hours af To the Funeral Di completely filled in

1 N Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 □ Donation 5 □ Other (Specify) 21. Bignatural of Funeral Service Licen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. à Completed 25. Was casa refarred to medical axaminer? 8 1 Yes 2 No 2

4 Homicide

29a. Certifier

19a. Informant's Name/Relationship (Type, Print)

Kathryn C. Hafner

20a. Method of Disposition

EPILEPTICUS STATUS BACTEREMIA

Due to (or as a consequence of): URINARY RACT Dua to (or as a consequence of): EPIDURAL

/ Friend

LNFECTION

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code)

1242 Stevens Avenue, Arbutus, Maryland 21227

.22. Nama and Address of Facility Hubbard Funeral Home, Inc.

Data

4107 Wilkens Avenue, Baltimore, Maryland 21229

ABSCESS

20b. Place of Disposition (Name of cematary, crematory or other place)

Mt. Olivet Cemetery

2 MONTHS 23b. Did tobacco usa contributa to the causa of death? 1 Yaa 2 No 3 Probably 4 Unknown

20c. Location - City or Town, Stata

9/23/98 Baltimore, Maryland

WUADRIPLEGIA

24a. Was an autopsy performed? 2 No

28d. Describe how injury occurred

26. Place of Death (Check only ona)

24b. Wara autopsy findings available prior to completion of causa of death? 1 ☐ Yas 2 ☐ No

Approximata Intarval Batween Onset and Death

2 DAYS

6 DAYS

6 DAYS

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 2 Accident 6 Could not be 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 28b Time of

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

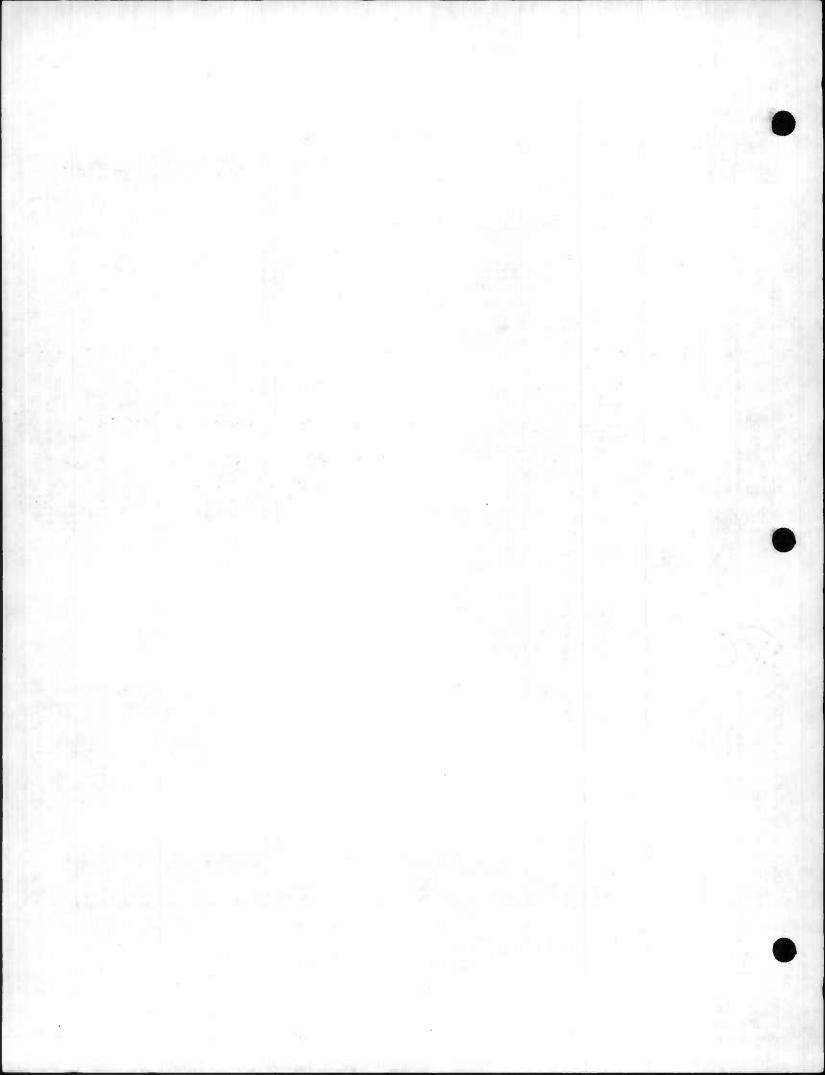
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at tha time, date and place, and dua to the cause(s) and manner stated. 29b. Signature and title of certifier Rachna Gupta

29c. License number P1240+ 29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) SOUTH GREENE STREET, BALTIMORE, MARYLAND

KACHNA GUPTA, MD 22 31. Data filed (Month, Day, Year) 32. Registrar's Signatura SEP 2 5 1998

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Amend: #7,8 Per FH Film G764 10-1-98RC Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 11:55 AM 1998 September 21 <u>Jashbhai Gokaldas Patel</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 1922 If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** Months Days 10XM 2□ F 73 76 Yrs. $31, \frac{1925}{}$ Director JULY India None Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10e State 10b. County d 2 should be filed within 72 hours after death with the Maryla th and Menial Hygiene. 7 Is marked ordher than "natural", or itema 23a or 28a-f show traumatic event, it a Medical Exertine trust be notified. 1 Yes X No MD Howard Clarksville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21029 7319 Meadow Wood Way Britain Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Asian Indian by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Printing Shop 12 Business Owner 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Ujamba Patel Gokalbhai Patel 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Inlomant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is m any injury or other traum pncs. 7319 Meadow Wood Way Clarksville, MD 21029 Timir Patel / Son altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removel from State Metro Crematory, Inc. 9/24/98 Baltimore, MD 4 ☐ Donation 15 ☐ Other (Specify) 22. Name end Address of Eacility Cremation Society of Maryland, Inc. McDonald Dawn 299 Frederick Rd. Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart leilure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** Acute my ocardial infarction Immediate Cause (Final disease or condition resulting in death) /Medical Examiner rdiogeniz & huck
Due to (or as a consequence of): Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest edical Due to (or es a consequence of): Box Physic 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown P A 24a. Wes en autopsy performed? 24b. Were eutopsy findings available prior to Completed completion of ceuse of death? page 2 1 ☐ Yes 2 ☐ No confilicate Be 25. Was cese referred to medical 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1- Inpatient 2 ER/Outpetient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1. Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28l. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, Ierm, street, factory, office building, etc. (Specify) Bitter 4 Homicide 6 in 24 hours a the Funeral C spletely illed Hospital 1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner stated. 29e. Certifier edical To the To To the To the I 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

State

Registrar

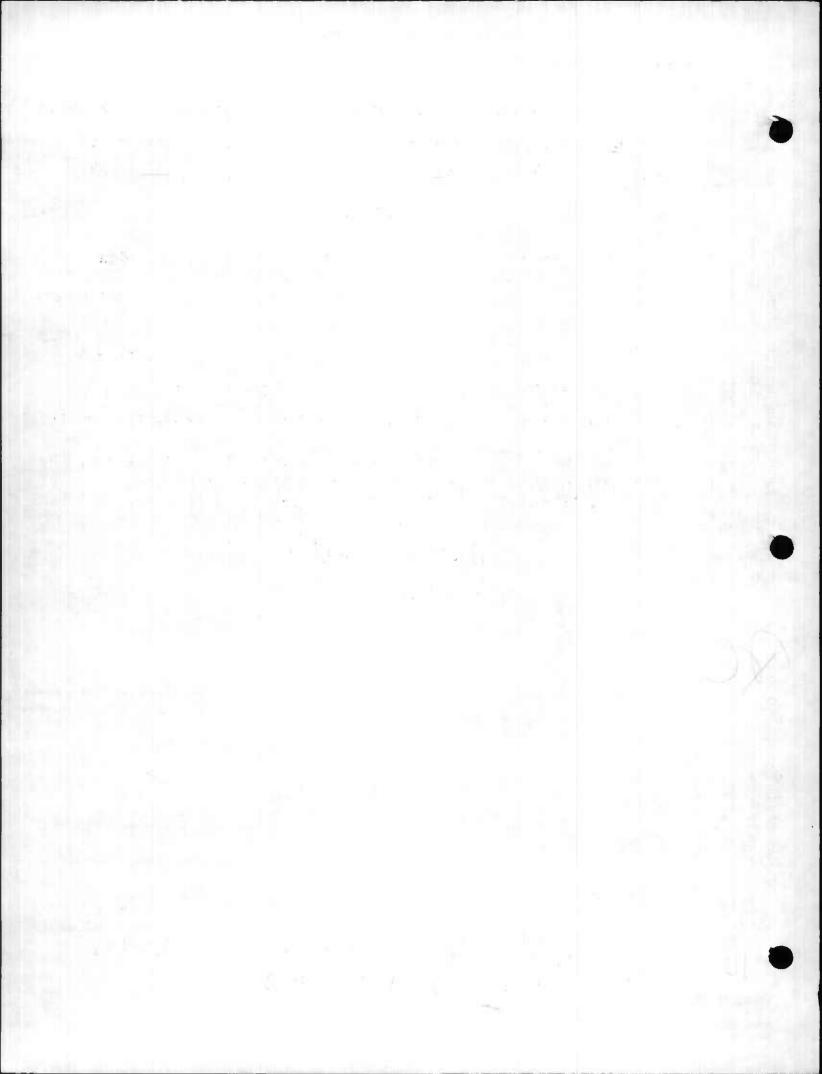
D 45112

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print) CHETAN PATEL W

31. Dete liled (Month, Day, Year) SEP 2 5 1998

32/Registrer's Signeture

Darks



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lee PANUSKA 23:40 BONNIE september 22, 1948 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5 Social Security Number Birthpiece (State or Foreign Country) **Funeral** 10M X F Days Yrs. 213-64-2833 45 **Director** June 2, 1953 Maryland Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 28 No Directo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours effer deeth with Department of Health and Mental Hygiene.

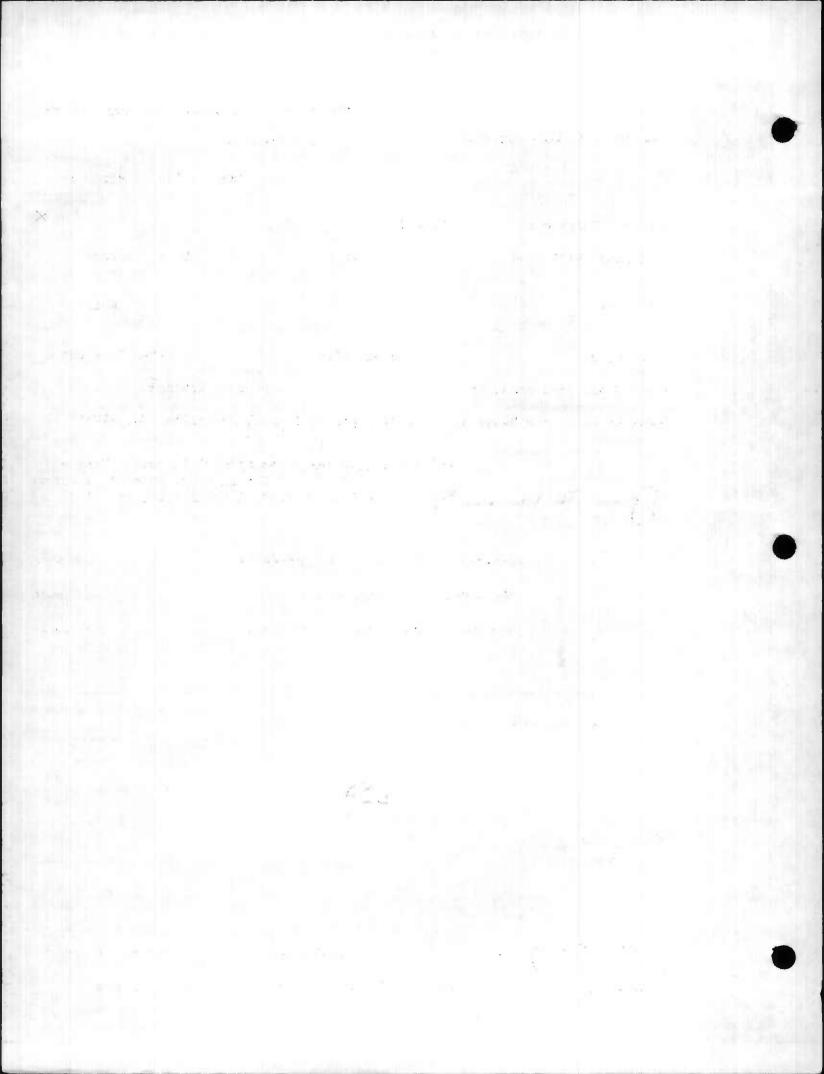
Important: If item 27 is marked other than *--any injury or other traument. with "naturel", or items 23a or adical Exercises must be 21234 United States 2922 Aspen Hill Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) United Book Press 12th Grade Receptionist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Dorothy Bell Robinson James Edwin Zimmerman, Sr. 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2922 Aspen Hill Road; Parkville, Md. 21234 Jennifer Panuska - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns. 9/26/98 Timonium, Maryland 21. Signature of Funeral Servica Licanses 22. Name and Address of Fecility Loring Byers Funeral Directors dr. 8728 Liberty Road; Randallstown, Md. 21133 23a. Part. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical e. refractory intracranial

Due to (or es e consequence of): 11 hours Examiner Obstructive hydrocephalus

Due to (or as a consequence of): Physician/Medical Examin 11 hours Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760, probable 13 hours brain etem Due to (or as e consequenca of): the death certificate use Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by the e 1 Yes 2 No 3 Probably 4 Unknown Cardine asystole ģ 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy performed? Completed hes certificate he lirector, page 2 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? if or Attending P efter deeth. I Director: After I d in by the funer After 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined To the Hospital or Atterwithin 24 hours effer der To the Funeral Director completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and menner as stated.

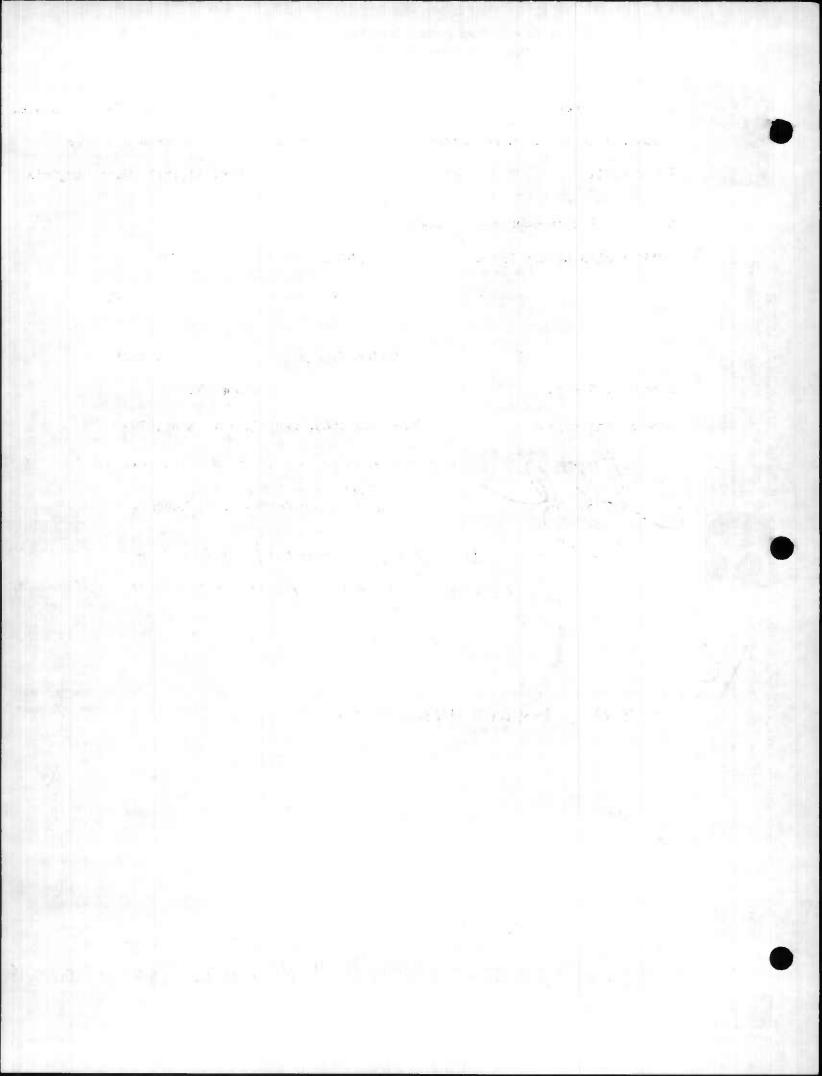
Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signeture end little of a rtifier 29c. License number 29d. Date signed (Month, Dey, Year) RES-000 23, 1998 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Wang, Baltimore, 600 North Wolfs Street. Maryland 31. Date filed (Month 32. Registrar's Signature State

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 91

				C	ertificate of		R	eg. No.	29492		
	n	1. Decedent's Neme (First, Middle, La	est)				2. Date of Deel		3. Time of Death		
	Physician /Medical	Mary F. Reid						er 19,			
3	Examiner	4e Fecility Name (If not institution, given				4b. City, Town, or I	ocation of Deeth	4c. County o	of Deeth		
		Harbour Side Hea	Bowie		Prince	e George					
	Funeral Director	578-28-5011	Sex 7. Age	(In yrs. last birthd 85 Yrs	Months Devs		8. Dete of Birth (Month, Day) Dec. 11	Year) ,1912	9. Birthplace (State or Foreign Country) West Virginia		
	pur *	Usual Residence of Decedent 10a, Stete 10b, County		10c. City, Town o	Location				10d, Inside City Limits		
	short short								1 ☐ Yes 🏋 🔯 No		
	or 28s-f sl or 28s-f sl or notified	MD Prince	George	Bowie	10f. Zip Code		1	0g. Citizen of Wi			
	23a or unith unith rail Dir	15005 Health Cen	ter Drive		20716			USA			
21215-0020	n 72 hours after death with the Maryland "natural", or frems 23a or 28a-1 show adreal Examiner must be notified at leted by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes:	iver in U,S.	3. Wes Decedent of If Yes, specify Cult 1 ☐ Yes ②\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		pecify Yes or No- o Rican, etc.)	Bleck	- American Indien, c, White, etc. White		
2-0	ed within 72 ho ygiena. Per than "naturn it, the Medical Completed	15. Decedent's E		16e. De	16e. Decedent's Usuai Occupation (Give kind of work done during most of working			16b. Kind of Bus	iness/Industry		
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Maryland	金工を の	17. Father's Neme (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, I	Meiden Sumeme)		
/la	should be nd Mental marked c umatic sv	Arthur A. Fletch	er			Mary C	rumpacke	r			
a	and I and I s me	19e. Intorment's Name/Reletionship	(Type, Pnint)	19b. M	ailing Address (Stree	et end Number or Au	rel Route Number	, City or Town, S	State, Zip Code)		
	D 5 1 5	Fred A. Miller/S	on). Box 256	6, Laurel	, Maryla	nd 2070	9		
Baltimore,	ーエラも	20e. Method of Disposition	Demouel from State	20b. Plece of Di cemetery,	sposition (Neme of cremetory or other pl	/ece)	Date	20c. Location - C	City or Town, State		
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alti	permit. Pages Department of Important: If its eny injury or o	21. Signature of Fineral Service Lice	hyd		22. Name and Add	ress of Fecility					
m	Dep Imp eny eny	1 128 1			Fleck F	uneral Ho	me, Inc.				
		23a. Page Enter the disease, or con	polications thet caused	the death. Do not	enter the mode of dy	ndy Sprin	g Road, or respiretory err	Laurel,	MD 20707 Approximete		
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Vital	certificata rector, pag	25. Was case referred to medical examiner?	11				eth (Check only or	ne)			
hys hys	hys hys	1 Yes 2 No	Hospital: 1 Inpatie		itient 3LI DOA		lome 5 Resid				
	fter the transfer transfer to on:	27. Manner of Death 1 SD atural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Tim Inju	ry W	ork?	28d. Describe h	ow injury occurre	ed .		
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	To the Hospital or Att within 24 hours after of To the Funeral Direct complately filled in by Medical Certiff		hyaician: To the best o miner: On the basis of end menner sta	examination and/o							
	within 2 To the comple	29b. Signature and title of certifier	070 ac)		nse number			(Month, Day, Year)		
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	11	20 Name and address of names it	completed serves of the	oath (item 22a) (F	ne Print) A4	11 1	-	10	10		
	4	30. Name and address of person who	1-400	0-1	challo	We road	:#22	o. Bow	1606-GAL		
	State	31. Date tiled (Month, Day, Year)	32. Regiftra	r's Signeture							
	State Registrar	SEP 25	1998 See	www.	9 1	1,					



Physician /Medical Examiner

Funeral Director

the Manylenc 28a-1 show 7 is marked other than "naturel", or items 23a or 28a-f shot traumatic event, the Medical Examinet must be notified at

death permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. If them 27 is marked other than "naturel", or then eny Injury or other traumatic event.

Saltimore, Maryland 21215-0020

Physician /Medical Examiner

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Box 68760 Division of Vital Records, P.O. certificate Hospital or Attending Physician: funerel director, this deeth. after deeth Director: 24 hours a To the Vilhin 2

State Registrar

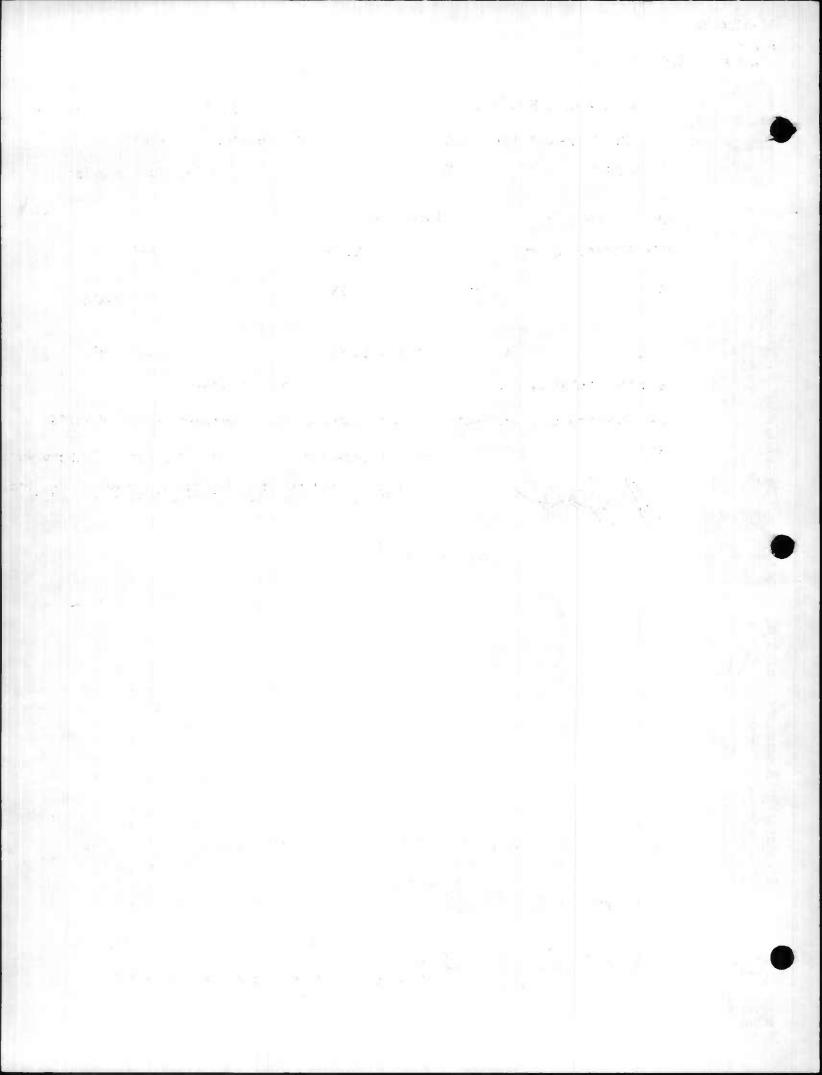
1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Day Lawrence Albert Schultz, III 18, 1998 SEPT. 0356 AM 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death 70 WEST AT MARRIOTSVILLE ROAD Marriotsville HOWARD If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dev. Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1XXM 20 F Months Days 28 213-04-3624 June 19, 1970 Maryland Usuat Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 1□ Yes ANNO Director Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1999 Advisory Court 21784 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 Wo If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Merried 2 Married 1 Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Retail Clerk U.S. Postal 18. Mother's Name (First, Middle, Maidan Surname) 17. Father's Name (First, Middle, Last) Lawrence Schultz, Jr. Michele Senkus 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Lawrence Schultz, Jr./Father 1999 Advisory Court, Eldersburg, Maryland, 21784 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XBuriaf 2 Cremetion 3 Removel from Stete Crestlawn Cemetery 9/22/98 Marriotsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name end} Address of Feclity
Gary L. Kaufman FH @ Meadowridge Memorial Pk. Inc.
7250 Washington Blvd, Elkridge, Maryland, 21075 e, or cemplications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, List only one cause on each line. Immediate Cause (Finel Head disease or condition resulting in death) injunies Due to (or as a consequence of) Examiner Sequantially list conditions, it any, leading to immediata cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Due to (or as e consequence of) **Physician/M** 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings aveilable prior to complation of causa of daeth? 24a. Wes an autopsy performed? Completed 1 Yes 2 □ No 1 No 2 No 25. Was casa rafarrad to medical axaminer? 26. Placa of Death (Check only one) Be Other: 4 Nursing Home 5 Residence XXOther (Specify) AT SCENE XXYas 2□ No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Found M 1 Natural 5 Pending 1 ☐ Yes 2 🔀 No investigation 9-18-98 2 Accident Automobile accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 70 West / Marriotsville 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Street Howard County, Maryland Certifying Physicien: To tha best of my knowledga, daeth occurred at tha tima, data and place, and due to tha cause(s) and manner as steted.

XX Medical Examtner: On tha basis of examination and/or invastigation, in my opinion, daeth occurred at the time, date and place, end due to the cause(s) 29a. Cartifiar Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number SEPT. 18, 1998 O.C.M.E 30. Name end address of person who completed cause of death (flam 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Radentz Stephen 5,

31. Date flied (Month, Day, Year) SEP 2 5 1998

32. Registrar's Signature

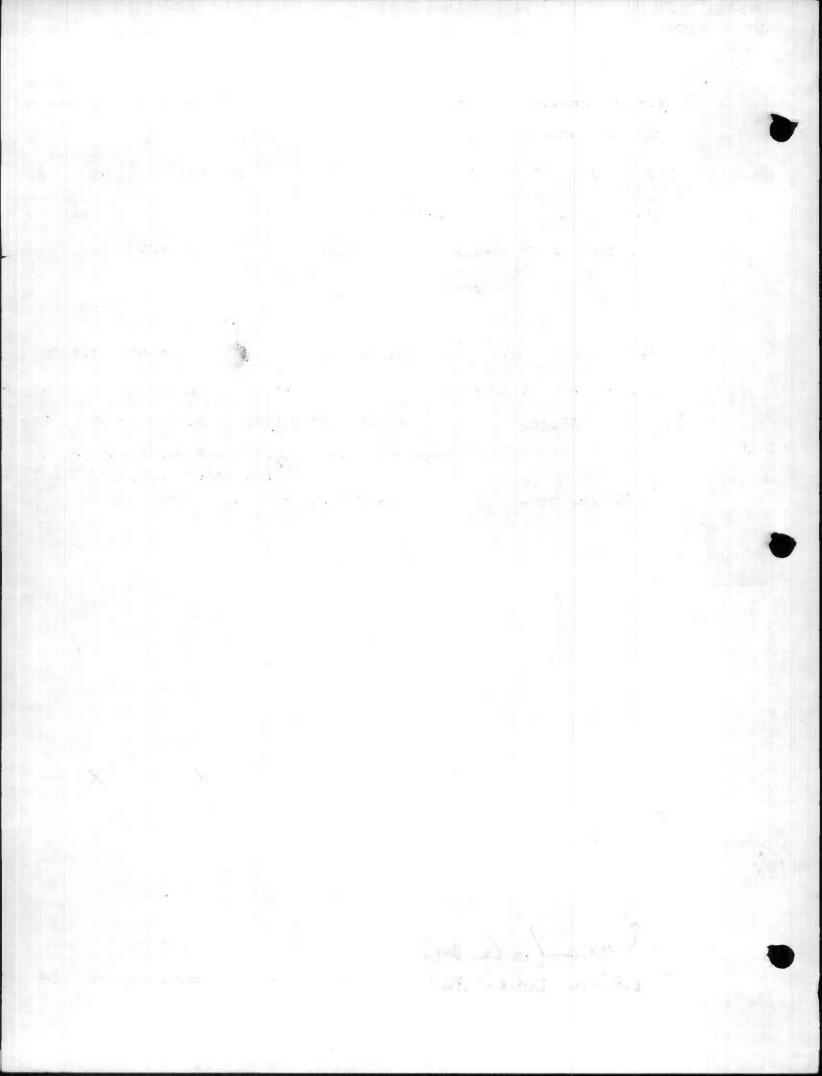
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ASP State of Maryland / Department of Health and Mental Hygiene ITEMS: #23 PER PART I, II, 27 PER MEO G763 10-1-98 WR. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day SEPTEMBER **Physician** 21 1998 Albert Steven Slocum 3:16 A /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2483 DRUID HILL AVE BALTIMORE If Under 1 Year If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 6 Sax 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours XIXM 2 F 47 04-26-51 Director 212-56-7348 MD Usual Residence of Deceden the Maryland 10c City Town or Location 10a State 10b. County 10d inside City I imits 28a-f show r than "natural", or items 23a or 28a-f show to Medical Examiner must be notified at Baltimore MD NA XX Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 2483 Druid Hill Avenue 21217 USA e death Funer Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on of Health and Mental Hygiane.
nt: if item 27 is marked other than "natural", or item 1 ☐ Yes 2X No 1 Never Married 2 Married 1 ☐ Yes 2☐No Specify: Specify: Black Baltimore, Maryland 21215-0020 2 3 Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 11th Grade NA Laborer various trades traumatic event. 18. Mothar's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Patterson Martha Roland E. Slocum 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 540 East 22nd Street Baltimore, MD. 21218 Slocum Martha other 1 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Department o Important: If any Injury or 0 Kings Mem. Pk. Ce. 09-25-98 Randallstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Servica Licanses WM.C.March FH 1101 E. North Avnue 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SEIZURE DISORDER Examiner Dua to (or as a consaquenca of) Examiner Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Causa (Disaasa or injury that initiated evants resulting in death) Last Dua to (or as a consequanca of): pur physician Physician/Medical Due to (or es e consequence of): å. 12 987 b 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ž 1 Yes 2 No 3 Probably 4 Unknown 6 CHRONIC ALCOHOLISM of Vital Records. p 奥 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy Completed Yes 2 | No Yes 2 No 91 Be 25. Was case referred to medical examiner? 28. Placa of Death (Check only one) Other: 4 Nursing Home 5 DResidence 6 Other (Specify) 1 Yes 2 No 0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: invastigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical 9 å o the o 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signator and title of certifier O.C.M.E SEPTEMBER 21,1998 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 111 Penn Street, Baltimore, Maryland 21201 no

State Registrar 31. Date filed (Month, Day, Year) SEP 2 5 1998



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Amend: #17 Per FH Film G764 10-2-98RC Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Beatrice L. Slaughter Sept.22, 1998 9:40am /Medical 4b. City. Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Pleasant Living Convalescent Center Edgewater Anne Arundel 7. Age (In yrs. lest birthdey) If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dev. Yeer) **Funeral** Days Months Hours 10M 30F 92 213-74-5923 Director Aug. 21, 1906 Kentucky Usuel Residence of Decedent the Meryland 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r is marked other than "natural", or items 23s or 28s-f show traumstic event, on Med call Examinal names or notified at 1 ☐ Yes 2√ No Directo Anne Arundel Deale 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with P.O. Box 58 20751 USA Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Mental Hygiene. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 157 Never Merried 2 Married 1 ☐ Yes 2X No Specify: White Specify: by 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 0 Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Frank Slughter FRANK SLAUGHTER Ollie Payne 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Edward W.Germann-Friend P.O. Box , Deale, MD 20751 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Buriel 2 ☐ Cremetion 3 ☐ Removel from State Rock Creek Cemetery 9/25 Washington, DC 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fungral Service Licenses 22. Name end Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD enter the mode of dying, such as cardiac or respiratory errest, 21401 Approximete 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Intervel Between Onset and Death **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner Mexia Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Bud nemia Due to (or as e consequence of) Division of Vital Records, P.O. Box 681 cer of the wayx 3 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 3 p 24b. Were eutopsy findings eveileble prior to 24e. Wes en autopsy performed? Completed peen completion of cause of death? hes The T 2 No certificate 1 ☐ Yes 2 ☐ No After this certification, funeral director, g or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homlcide 24 hours a Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

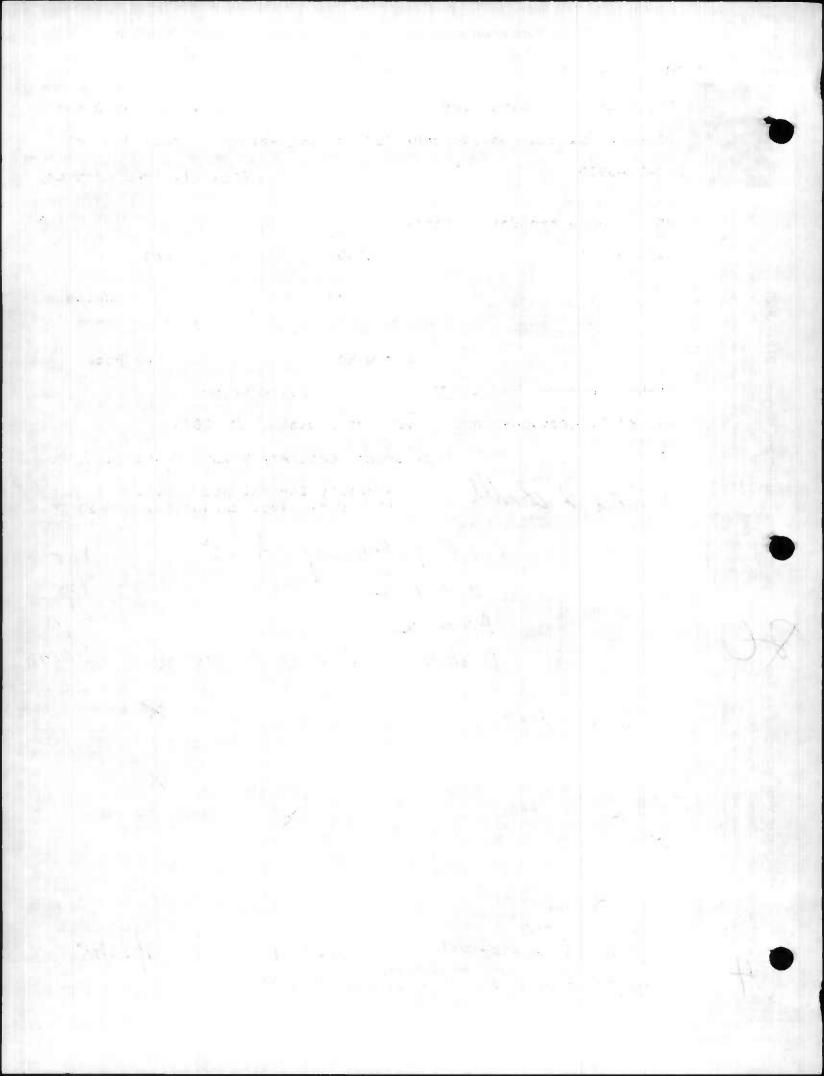
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner stated. edicai 29a. Certifier (Check only one) within 2 the th 29b. Signeture and title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 0

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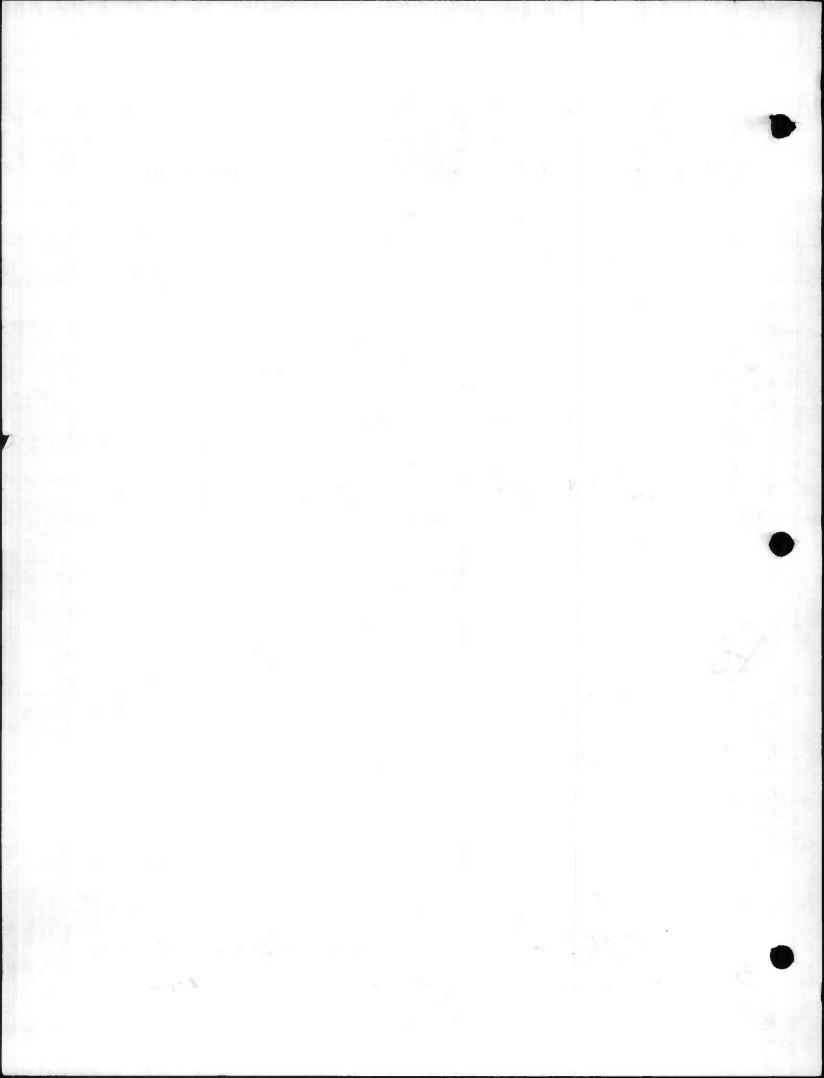
31. Dete filed (Month, Day, 1 SEP 2 Registrar

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30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Annaholis 32. Fegistrer's Signeture ener



Physician Theorem and number and				State of Marylar				Death		Reg. No.	29496
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Am 25568964109 9/22/98	n 24 houn		(Check only 2 Medical Exam)	ner: On the besis of exemine	owledge, deeth otion end/or inve	occurred	et the ti	me, dete end piec opinion, deeth occ	e, end due to the urred et the time	e cause(s) end me o, date end place,	enner es steted. and due to the ceuse(a)
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ELLC SKLAN, 301 ST. PAUL PL, BALTIMONE, MD 202	2		30. Neme end address of person who co	empleted ceuse of deeth (iter	n 23e) (Type, P	Print)	m ?	2556896	41109	9/27	198
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 1998 Charles Edward Seebo Sept 2100 22 4b. City. Town, or Location of Daath 4a Facility Nama (If not institution, give streat and number) 4c. County of Death St. Agnes Hospital Baltimore If Undar 24 Hrs.
Hours Min.
NOV 13, 1917 5. Social Sacurity Number If Undar 1 Yaar 6. Sex ↑□ M 2□ F Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Months Days 215-07-9675 80 Yrs Maryland Usuel Rasidance of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits MD Baltimore Baltimore 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1120 Dorchester Avenue 21207 USA Was Decedant Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☐ No If Yes, Giva X Yaar or Datas: Specify: White 1 Yas 2 No Spacify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Local 100 Sheet Metal Worker 18. Mothar's Nama (First, Middla, Malden Surnama) 17. Father's Name (First, Middle, Last) Charles Seebo Mary Gill 19b. Mailing Addrass (Straat end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 1120 Dorchester Ave. Baltimore, MD 21207
of Disposition (Nema of Dete 200. Location - City or Town, Stata Jeanne C. Seebo / Wife 20b. Placa of Disposition (Nema of cematary, cramatory or othar place) 20a. Method of Disposition 1 Burial 2 ☐ Cramation 3 ☐ Removal from Stata Woodlawn Cemetery 9/25/98 Woodlawn, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Eureral Service Liçansee MacNabb Funeral Home, P.A. Edward A. 301 Frederick Rd. Baltimore, MD 21228 F ward A. Gregoren 301 Frederick Rd. Balti 23a. Parti. Entar tha disaasa, or complications that caused tha death. Do not anter tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death Immediate Causa (Final disaasa or condition rasulting In daath) <24 hours a Cerebro Vascular accident Due to (or as a consaquanca of): Saquantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury thet initiated events rasulting in deeth) Lest Dua to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 20 No 3 Probably 4 Unknown Coronary Artery disease 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy Congestive Heart failure complation of cause of daath? 1 Yas 2 No 1 □ Yas 2 □ No 25. Wes cesa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1□ Yas 2 No 1) Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accidant

P.O. Records, à Completed page 2 y 89 Charles 918 Certification: after deatl Director:

Physician

/Medical

Examiner

Director

Funeral

P

Completed

Funeral

Director

item 27 is marked other than "natural", or items 23s or 25s-f show other traumatic event, the Medical Example must be notified at

2 should be filed within 72 hours after death in and Mental Hygiene.

1s marked other than "natural", or items 23s

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum

Physician /Medical

Examiner

altimore, Maryland 21215-0020

with the Maryland

To the Within 2 To the

State Registrar (Resident

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SC Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and dua to the cause(s) and mennar es stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and mannar stated.

29c. Licensa number

29d. Data signed (Month, Dey, Year) September 22, 1998

28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta)

30. Nama and eddrass-of person who complated causa of daath (Itam 23a) (Type, Print)

6 Could not be determined

3 Suicida

29a. Certifier (Check only one)

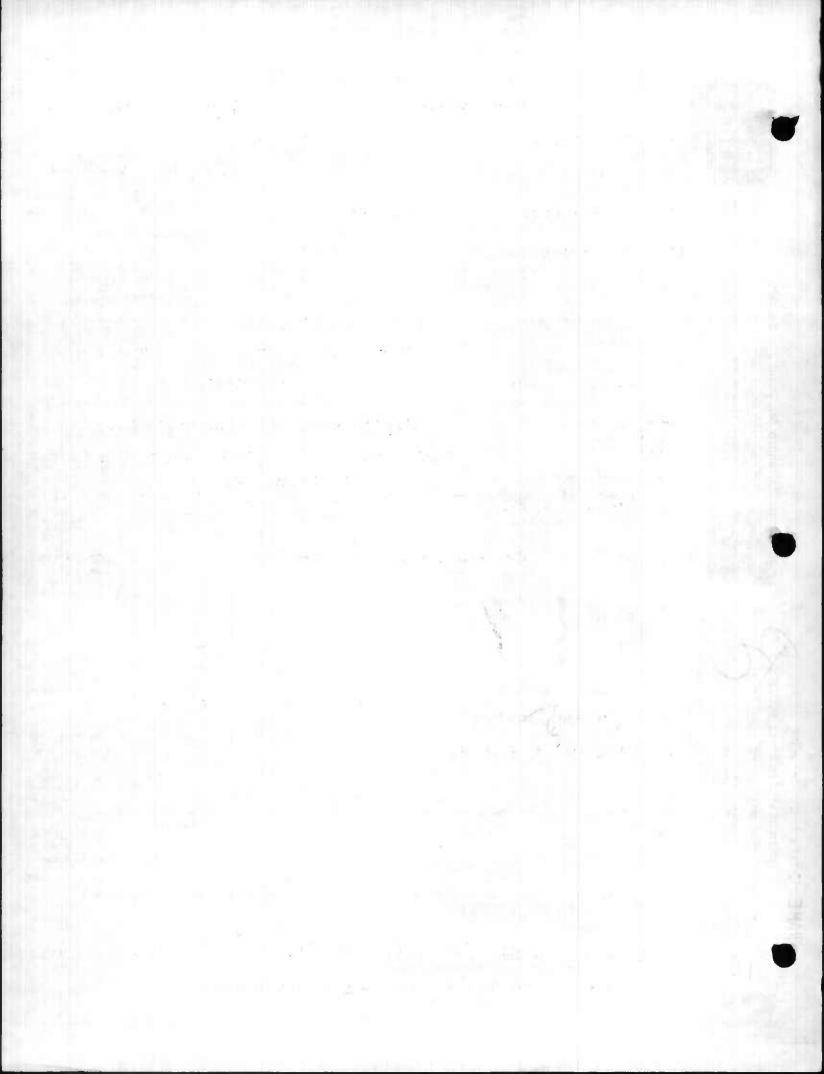
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29b. Signature end title of certifiar

900 coton Ave Baltimore Md 21229 mD Liberoni 31. Date filed (North, Dey, Yeer) SEP 2 5 1998

32. Registrar's Signatura ilpera

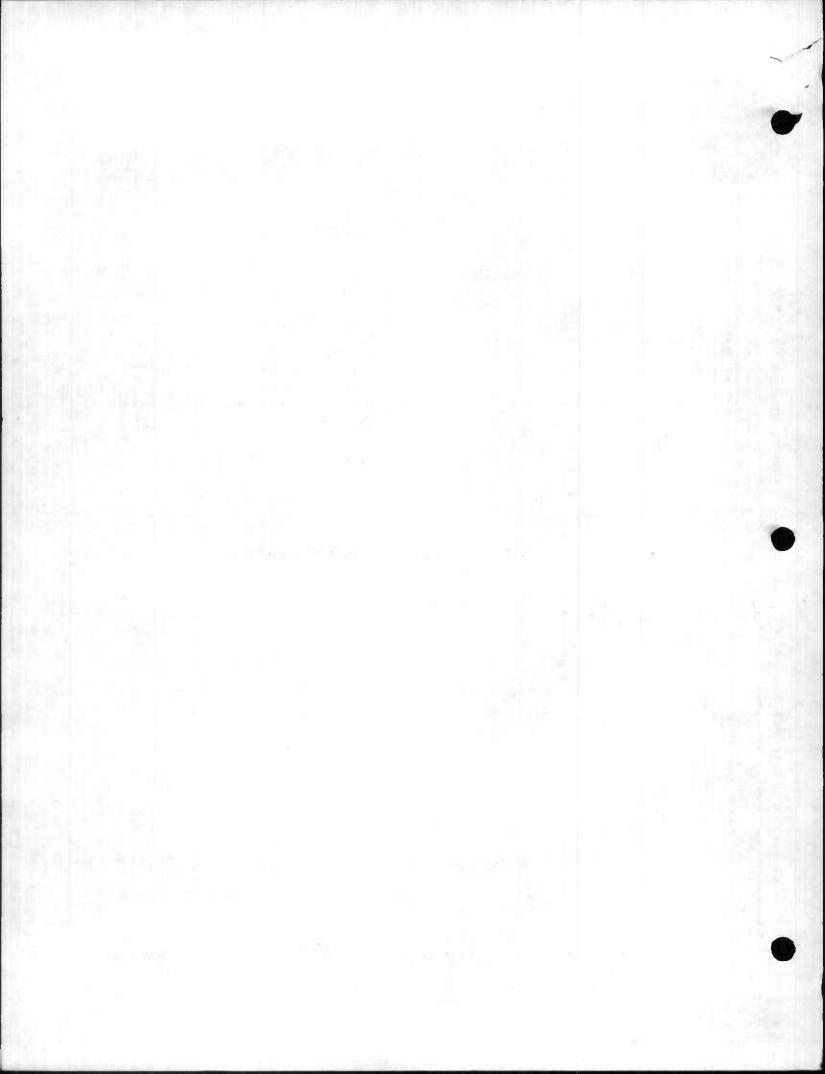
28a. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify)



State of Maryland / Department of Health and Mental Hygiene

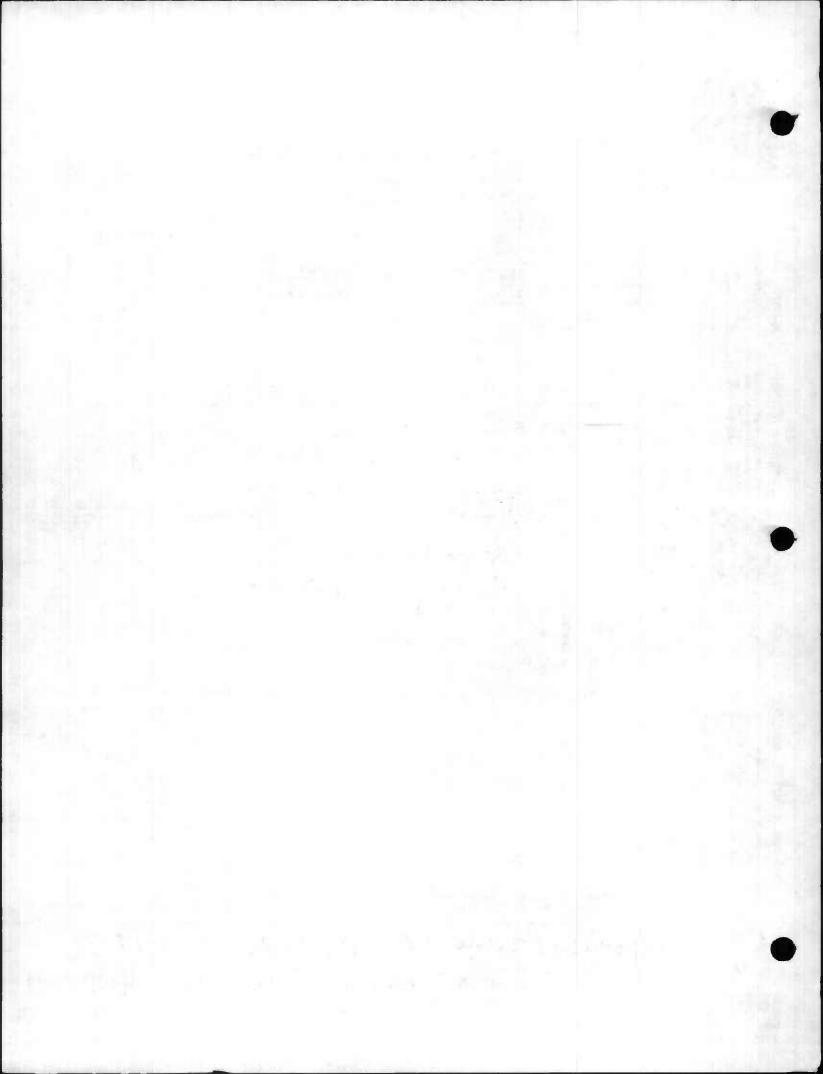
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William Joseph Facility Neme (If not institution, giv 3502 Ellen Road Scientis Number 0-12-6453 al Residence of Decedent State 10b. County ryland Baltimore Street and Number 02 Ellen Road Marital Status 10 Never Married 15. Decedent's Ed (Specify only highest gra ementary/Secondary (0-12) 12 Father's Name (First, Middle, Last) William Theodore Informant's Name/Fielationship (0-12) Method of Disposition 1. Marital 2 Commation 3 C 4 Contact of Specify Signature of Funeral Service Licentise	Schwarze e street and numbe d lex N N 2 F 7. N N 2 F N N N N E County 12. Was Deceder Armed Forcer 1 N Yes 2 If Yes, Give 1 Yes, Give Sugain of Dates sugain of College (1-40 N A N N E Schwarz	Rock T1 10c. City. Rock St Ever in U.S. Place WWII	Yrs. Town or Lo cdale 16a. Decse (Give	Months 101. Zig Was Dece If Yes, spe dent's Usus kind of wo	Days Code 21244 dent of Fedly Cubs all Occups of done	dispanic Origi an, Mexican, Specify:	S S S S S S S S S S S S S S S S S S S	Date of Birth (Month, Day AN . 13	Dey 19, 19 4c. County Balt: Year) 1927 Og. Citizen of V U.S.	9. Birthple County Mary	n Indian.
acility Neme (If not institution, given 3502 Ellen Road octal Security Number 6.8 0-12-6453 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e street and number d Sex 7. / M 2 F 7. / E County 12 Was Deceder Armed Force 1 M 9es 2 E If Yes, Give Year or Dates Sucation de completed) College (1-40 N/A e Schwarz Type, Print)	Rock T1 10c. City. Rock St Ever in U.S. Place WWII	Yrs. Town or Lo cdale 16a. Decec	Months 101. Zig Was Dece If Yes, spe dent's Usus kind of wo	Days Code 21244 dent of Fedly Cubs all Occups of done	Rockda: If Under 2 Hours Hours A In Mexican, Mexican	n, or Loca le 4 Hrs. 8 Min. J	Sept. Ition of Death Date of Birth (Month, Day AN . 13	4c. County Balt: Year) 1927	of Death Imore 9. Birthple County Mary What County A.	County ace (State or Fore 2) Land d Inside City Limi 1 Yes 2 2 2 2
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4 □ Donation 5 □ Other (Specif)		20b. Pti	ace of Dispo	sition /Na	me of				20c. Location -		
Signature of Funeral Appaign Lines		9					09/	22/98	Eldersh	nire.	Maryland
coldination of Continuo of Assistance Profes	1500	1 404				ss of Facility	401	22/30	ALGE LOL	,urg,	int y zano
spirick, or heart failure. List only	plications hat caus one tause on each	ed the death.	Do not ent	8728	Lit	erty I	Road,	Randa	ectors, 11stown	, Mar	yland 21 Approximate Interval Between Onset and Death
ase or condition	ARTERI				-	SCULAR	DISE	ASE		-	YRS.
uentially list conditions,	b	Due to (or	as a conseq	quence of):						-	
if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										-	
L	d										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						ren in Part I.		23b. Did to	obacco use co	ntribute to	the cause of deat
							104	es 2 No	3 Probe	ably 4 Unkno	
	T. 商业等。							24a. Was a perform	n autopsy med?	avai	re autopey finding lable prior to pletion of cause eath?
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	Hospital: 1□ Inpa	tient 20E	P/Outpetien	w 3C) Do	OA OB	war	-		5.4	er (Specify)	
anner of Death XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Desc										
determined.	ZBB. PRICE OF I	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28	City or Town	treet and Numb n, State)	ber or Rural	Route Number,
Certifier 1☐ Certifying Phy (Check only 2 Medical Exem	tiner: On the basis	of examination	fedge, death on and/or inv	occurred vestigation	at the tir , in my o	me, date and pinion, death	place, and occurred	d due to the c at the time, d	ause(s) and me ate and place,	anner as sta and due to t	ted. the cause(s)
Signature and office of certifier		\		29	c. Licens	e number		2	9d. Date signe	d (Month, D	ay, Year)
Voh. 0	IM	10	.00	A	D-0	9383			, S. A	-1	40 00
lama and address of names who	10h	dualty Days	cells	PCK)	-				40	ouper	20,179
with a second of purpos with C	NNELL, M.		0.00	100		n 1 / 0			-		21210
The same of the sa	was case referred to medical stanner of Death Death Could be conditions	ARTERI asse or condition alting in death) Declared to immediate ase. Enter Underlying ase (Disease or injury initiated events alting in death) Last Declared to medical examiner? If Yes 2 No Was case referred to medical examiner? Asserting in death Was case referred to medical examiner? Asserting in death Was case referred to medical examiner? Asserting in death Continue to death Mospital: 1 Input Was case referred to medical examiner? Asserting to death Mospital: 1 Input Was case referred to medical examiner? Asserting to death Continue to death Could not be determined Continue to the basis and manner of the continue to the basis and manner of the continue to the death Signature and site of certifier Signature and site of certifier Signature and site of certifier Signature and site of certifier	ARTERIOSCLER a. ARTERIOSCLER a. Due to (or b. 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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ITEMS: #19	-A PER F.H. G763 9-29-98 WR.	Certificate			g. No.	29499		
Physicia	Decedent's Neme (First, Middle, Last)			2. Date of Death Month		3. Time of Death		
/Medica	Maude Mae Loudenslager Kir	k Smith		Sept.	16, 199	8:15 A.M.		
Examine		4e Fecility Neme (If not institution, give street and number) 4b. City, Town, o						
40	6909 Dogwood Road 5. Social Security Number 6. Sex 7. Age	/In vrs. last hirthday) If Under 1 Yo	Woodlawn	0.0-1(0:4)		nore County		
Funeral Director	5. Social Security Number 216-52-6508 Usuel Residence of Decedent 6. Sex 1	Months Da	ys Hours Min.	8. Date of Birth (Month, Day, MAY 22,		9. Birthplace (State or Foreign Country) (aryland		
ehow of a		10c. City, Town or Location				10d. Inside City Limits		
Man	Maryland Baltimore	Woodlawn				1 ☐ Yes 2 XXVo		
ther death with the Maryland referre 28 or 28 or 4 show there are notified at	10e. Streef and Number 6909 Dogwood Road	10	Og. Citizen of WI					
5 2 5	11. Menitel Stetus 12. Wes Decedent Every Armed Forces? 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Year or Detes:	If Yes, specify 0	of Hispanic Origin? (Sp. Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)		- American Indian, White, etc. White		
72 hours	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usuel Oc	cupation		16b. Kind of Bus			
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene. Tie marked other then "natural", or traumatic event, tre Medical Errori traumatic event, tre Medical Errori	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) N/A	16a. Decedent's Usuel Oc (Give kind of work do lifa. DO NOT use re Homemaker	one during most of work tired)	Own Home				
be filed that Hyging of other event, i	17. Father's Name (First, Middle, Last)	Homemarez	18. Mother's Name	(First, Middle, M				
Viar ould be Mental Mental Mental Mental	George Washington Loudensl	ager	Catherine	Igatha	France			
Maryland 212 42 should be filed with th and Mental Hygiene. The marked other ther traumatic event, tre.	19a. Informent's Name/Relationship (Type, Print)	reet and Number or Run			tete, Zip Code)			
	June K. Smith (daughter)	6909 Dogwoo	d Road, Woo	dlawn, 1	Maryland	1 21244		
ges 1 and to die to die Heali	20a. Method of Disposition 1 X Buriel 2 Cremetion 3 Removel from State	20b. Plece of Disposition (Name of cemetery, cremetory or other	plece)	Dete 2	20c. Location - C	ity or Town, Stete		
Fag ment ment:	4 □ Donetion 5 □ Other (Specify)	Ward's Chapel Co	emetery 0	9/18/98	Holbroo	k, Maryland		
Baltimore, permit. Pages 1 ar Department of Hea Important: if Nem 2 any Injury or other pince.	21. Signeture of Funeral Service Licensee		Byers Fune					
	23a. Perv. Enter the disease, or complications that caused the shock, or heart feilure. List only one cause on each line.		iberty Rd. dying, such es cardiac	Randalls or respiretory erre	stown, N	Maryland 21133		
Physician	shock, or heart feilure. List only one cause on each line.					Intervel Between Onset end Deeth		
/Medical	Immediate Cause (Finel disease or condition	al talune						
Examiner	resulting in deeth) 6.	ue to (or es a consequence of):						
D = 1	Coro	nary arlen	Deslas					
60, be executed sicial transit	Sequentially list conditions,	ue to (or es consequence of):						
68760, fificate be execut	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury							
5876(icate be physicia s the bur	that initiated events resulting in deeth) Last	ue to (or as a consequence of):						
death certification of for use								
S, P.O. BOX ss that the death cert gned by the attending be detached for use	Pert II. Other significant conditions contributing to death but	not resulting in the underlying cause	given in Part I.			ribute to the cause of death?		
es that es that ligned to be determined				1 U Ye	18 2 No	3 Probably 4 Unknown		
Ord require				24a. Was ar perform		24b. Were eutopsy findings available prior to completion of cause of death?		
The law ate has b page 2 s				1 ☐ Ye	s 210 No	1 Yes 2 No		
Vital Proceedings of the Contilicate inector, pag	25. Wes case referred to medical		26. Place of Deetl	(Check only one	9)			
of Vita Physicien: this certific	1 Yes 57YNo Hospital:	2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Ho	me 5 🖾 Reside	nce 6 □Othe	(Specify)		
OID OIL OIL OIL OIL OIL OIL OIL OIL OIL OIL		(sar) 28b. Time of fnjury 28c. I	njury at Work?	28d. Describe ho	w injury occurre	d		
Attending and death.	2 Accident investigation		1 ☐ Yes 2 ☐ No					
Division after death in by the	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury building, etc. (/ - At home, farm, street, fectory, offi (Specify)	ice	28f. Location (Str City or Town	reet and Numbe , State)	r or Rural Route Number,		
Division or Attending P within 24 hours after death. To the Funeral Director: After completely lilled in by the funeral Director.	29e. Certifier (Check only 2 Madical Examiner: On the best of e	my knowledge, death occurred at the	e time, date end place,	and due to the ca	use(s) and man	ner as stated.		
thin 2 the mple		d.	ense number					
To To So	I Grancis Brun	5MD D	09526		9-1	(Month, Day, Year) 7-98		
0	30. Name and address of person who completed cause of dee FRANCIS C BRUNO M	th (Item 23a) (Type, Print) M. D. Med Ae	to Build.	Colu	ım b ra	mD 21044		
State	31. Dete filed (Month, Dey, Year) 32. Registrers	s Signature	No. Account					



			1 December Name (Free Middle)		iai yiai			of Death		Reg. No.	9.8	2	9500		
П	Physicia	n	Decedent's Name (First, Middle, Li	nst)					2. Date of Month	Death Day	y Y	'ear	3. Time of Death		
	/Medica		Lamar Elmer Shutt						peptember 19,1990				7:00 A.1		
7	Examine	er								or Location of Death 4c. County of Death					
			7316 Rockridge Ro	oad				Villa N			altimo	ore (County		
	Funeral				ge (In yrs.	last birthday)	If Under 1 Ye Months Da	ear If Under 24 H		Birth Day, Year)	9	. Birthpla	ce (State or Foreign		
	Director		174-20-1220	1₹M 2□F 7	0	Yrs.			APR.	10,19	928 I		sylvania		
	ahow		Usual Residence of Decedent 10a. Stete 10b. County		10c. Ci	ty, Town or Loc	cation					10	d. Inside City Limits		
	with the Marylar a or 28a-f ahow be nothed at	ģ	Maryland Baltimon	ce County	Vi	lla Nov	a						1 ☐ Yes 2 No		
	128 In	Director	10e. Street and Number				10f. Zip Cod	la		10g. Citi	izen of Who	al Countr	γ?		
	23a o		7316 Rockridge R	and			2120	7		,	TT C A				
	to at	era	11. Marital Status	12. Was Deceden	f Ever in t	IS 13 V			(Specify Yes or		U.S.A 14. Race -	-	n Indian		
21215-0020	9 0 5	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 K Yes 2 If Yes, Give Year or Dates	? No	1	Yes, specify (☐ Yes 2]()	of Hispanic Origin? Cuban, Mexican, Pu No <i>Specify:</i>	erto Rican, etc.)			White, et	ic.		
ö	natural',	8	15. Decedent's E	MANTI		1	16a. Decedent's Usual Occupa			16h Ki	ind of Busin	nece/Indi	icto.		
5		Completed	(Specify only highest gr	ade completed)		(Give I	kind of work do	ne during most of v	vorking	100. KI	ING OF BUSI	1055/11101	istry		
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7	be filed within ttal Hygiene. d other than avant, the M		1.2 17. Father's Name (First, Middle, Last	5+		Schoo	I leaci		ame (First, Mide		olic S	scno	OIS		
5	S S S S	Be									Sumame)				
2	2 should be and Mental la marked of aurmatic ava	2	John Clayton Shu					Annie .	Jerome I	emke					
la	2 4 4	vi	19a. Informant's Name/Ralationship	Rural Route Nu	mber, City o	or Town, St	ate, Zip (Code)							
	5 1 2 5		Miriam Shutt (wi	lfe)		7316	Rockrid	lge Road,	Baltimo	ore, M	fary1a	and 2	21207		
a a	of Heat of Heat I Itam 2 r other		20a. Mathod of Disposition			Place of Dispos	sition (Name or	f place)	Data	20c. Lo	ocation - Ci	ty or Tow	m, State		
E			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont		9		-0.00	ery Maus.	100/22/0	A Line	d1 arm	. M.	amy land		
=		1	21. Signature of Funeral Service Lice		114 W			dress of Facility	09/22/	φ woo	JULAWI	l, Mi	arytand		
ä	Departi Importa any inj		1/100	11					neral Di	recto	rs. 1	Inc.			
		4	ph Da	3			8728 Li	Byers Fulberty Rd	Randa	lstow	m, MI	2.	1133		
		1	23a. Park. Enter the disease, or con spock, or heart failure. List only	on sause on each	ed the deal	th. Do not ente	er the mode of	dying, such as card	iac or respirator	y arrest,			Approximate Interval Batween		
		Examiner	Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury	a	Due to (or as a consequence or as e consequence	uence of);	STOMA	CH_				
	g d s	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to 1 Yes 2 No 3 Pro													
	the att	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause			the cause of death?		
	es that the de igned by the be detached	Dy Pny							1	□ Yes 2	□ No 3	Prob	ably 4 Unknow		
		Completed								as en autor erformed?	psy	avai	a autopsy findings lable prior to spletion of cause eath?		
Œ]	ate has	0							1	☐ Yes 2	No No	1□	Yes 2 No		
	certificate	90	25. Was casa referred to medical					26 Place of F	eath (Check on	ly one)					
> :		0	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ient 2	ER/Outpatient	3□ DOA	Other			e DOther	(Canaih)			
	Attanding Physic of death.	- 1	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D		28b. Time of Injury	28c. I	njury at Work?	Home 5 ☑ R						
S	death.	20	2 Accident Investigation 3 Suicide 6 Could not be						not teastic	- 1011	-1.00		0		
	after deat Director: d in by the	Certification:	4 Homicida determined	28e. Place of Ir building, e	itc. (Speci	ome, larm, stre	et, lectory, offi	09		Town, State		or Hurai	Route Number,		
	4 hour	BOILDE	29a. Certifier 1 Certifying Pt (Check only one)	ysician: To the best niner: On the basis and manner s	of examina	wledge, death ition and/or inv	occurred at the estigation, in m	e time, data and pla ny opinion, death oc	ce, and due to t curred at the tim	he causa(s) ne, date and	and mann pleca, and	er as sta d due to t	ited. the cause(s)		
	within 2 To the comple	Σ	29b. Signature and title of ceytiller	1			29c. Lic	ense number		29d. Da	te signed (Month, D	ay, Year)		
	,		12	1 no	1		1	25601	0	0	112	900			
	Y/	1	30. Name and address of person who	1/1/1	1	- 00-) CT	لا ا	22 00	h	7	100	119			
	101'		C DOLLC L 2 VI	completed cause of	oeath (Iter	n zsa) (Type, F	nnt)		0.41	C . A. =	1	-			
			31. Date filed (Month, Day, Year)	32 000	-KOJ	TROM	DIS	MATIN	mell	IND					
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